



Physical Examination Form

Students Last Name: _____ Students First Name: _____
 Date of Birth: _____

Instructions

The student named above has been admitted to Boston College. While in attendance at BC, the student may be eligible for and receive health care services at Boston College, University Health Services (UHS). It is beneficial for UHS to have knowledge of the student's current and past medical history. In addition, the student's immunization history must be up to date as defined by Massachusetts law.

Providers are asked to complete, sign and return this form to the student.

Students are asked to upload it to the [Health Services Portal](#) by July 1, 2023, for Fall Enrollment and January 1, 2024, for Spring Enrollment.

Physical Examination

(Must be within 12 months before registration)

Date of Physical Exam: _____ Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Pulse: _____

Please check each system below and indicate if it is normal or abnormal. Please give details in the "Explain abnormalities" section. If needed, please provide additional documentation.

System	Normal	Abnormal	System	Normal	Abnormal	System	Normal	Abnormal
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral vascular	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Chest/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	<input type="checkbox"/>

Recommended Labs for biological females: Hematocrit: Date: _____ Results: _____

Explain Abnormalities:

Health Conditions

Is this student currently under treatment for any medical or mental health condition? If yes, please include the condition and treatment plan:

Has this student suffered any major illness or injury in the past that we should be aware of?

Do you have any recommendations for this student's health care while at BC?

Has this student had chickenpox? Yes date: _____ No



Physical Examination Form

Fit for Sports			
<i>(This must be checked for participation in sports)</i>			
Is this student fit for Varsity or other sports? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Any contraindications to contact or non-contact sports?			
Allergies			
<i>(Please list ALL allergies to medications, foods, and other known reactions)</i>			
Or			
<i>(If the student has no known allergies, please check the box below)</i>			
<input type="checkbox"/> The student has no known allergies to medications		<input type="checkbox"/> The student has no known allergies to food	
Medication(s):			
Food(s):			
Other:			
Do they have an EpiPen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason:	
Current Medications			
<i>(List all prescription and non-prescription medications, including vitamins & herbal supplements, including dose and times per day)</i>			
Name	Dose	Frequency	Related Diagnosis

Signature of Provider _____ Printed Name _____ Date _____

Mailing Address _____ Office Phone _____