EMORY UNIVERSITY | Student Health Services
Campus Life

2025-2026 PHYSICAL EXAMINATION FORM

Allied Health, Medical and Nursing Students Only

Physical Exam must be **completed within one year of start date**. All incoming medical, nursing, and allied health students must return this completed, signed form **PRIOR TO MATRICULATION** through one of the following methods:

- Upload the form to your Patient Portal (**preferred**) **or**
- Email a pdf to immunizations-shs@emory.edu **or**
- Fax to: 404-727-7343 **or**
- Mail to: **Emory University Student Health Services**
  Attention: Immunization Department
  1525 Clifton Road NE, Atlanta, GA 30322

Student's Name: _____ Emory ID#:_____

Street Address: _____

City: _____State: _____ ZIP:_____Country:_____

Gender: ❒ Male ❒ Female ❒ Transgender: MTF FTM (Circle one) Other:_____

Date of Birth (mm/dd/yyyy): ____/____/____

Please select your degree program *(Circle One)*: AA DPT Genetic Couns Med Imaging MD Nursing PA Rad Tech

Do you now have or have you ever had:

	No	Yes		No	Yes		No	Yes
Allergies/Asthma	❒	❒	Epilepsy/Seizures	❒	❒	Positive PPD Test or IGRA	❒	❒
Cancer	❒	❒	Gastrointestinal Disorder	❒	❒	Psychiatric/Behavior Disorder	❒	❒
Cardiovascular Disease	❒	❒	Hepatitis/Jaundice	❒	❒	Pulmonary/Lung Disease	❒	❒
Diabetes	❒	❒	High Blood Pressure	❒	❒	Skin Problems/Disease	❒	❒
Endocrine Disorder	❒	❒	Kidney/Urinary Disorder	❒	❒	Tobacco/Vaping use (current or past)	❒	❒
Alcohol/Drug abuse (current or past)	❒	❒	Musculoskeletal Disorder	❒	❒	Eating Disorder	❒	❒

Other illnesses/Comments (please explain any YES answers from above): _____

_____

Allergies ❒ No ❒ Yes. If yes, list all allergies: _____

_____

Surgeries ❒ No ❒ Yes (list dates):_____

_____

Previous hospitalizations ❒ No ❒ Yes (list dates):_____

_____

Current medications ❒ No ❒ Yes (list medications): _____

_____

I attest that the information shown above is true and accurate to the best of my knowledge.

Student's Signature:_____ Date:_____

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*This page must be completed, signed, and stamped by a **non-relative** provider, nurse practitioner, or physician assistant.*

Patient's Name: _____ Emory ID#: _____ Date of Exam: _____

Height:_____ Weight:_____ BMI:_____ Temp:_____BP:____/____ Pulse:_____ RR:_____

Vision: OD_____ OS_____ OU_____ Without correction: _____

OD_____ OS_____ OU_____ With correction: _____

History/Current Alcohol/Drug abuse: ❒ No ❒ Yes _____

	Normal	Abnormal	Comments
HEENT	❒	❒	_____
Neck	❒	❒	_____
Lungs	❒	❒	_____
Heart	❒	❒	_____
Abdomen	❒	❒	_____
GU	❒	❒	_____
Extremities	❒	❒	_____
Neurologic	❒	❒	_____
Adenopathy	❒	❒	_____
Skin	❒	❒	_____
Psychiatric	❒	❒	_____

How long and on what basis have you known this patient?

Months:_____Years:_____ ❒ This visit only ❒ Professional basis

To your knowledge, does this patient have any significant medical problems? ❒ No ❒ Yes

Explain: _____

To your knowledge, does this patient have any emotional, psychological or psychiatric problems? ❒ No ❒ Yes

Explain: _____

Clearance to be able to withstand the rigors of his/her program of study:

❒ Physically and psychologically cleared for this program

❒ Not cleared:

- ❒ Pending further evaluation. Explain: _____
- ❒ Not Cleared: No pending evaluation

Healthcare Provider Signature: _____ Date:_____

Healthcare Provider Printed Name: _____ ❒ MD ❒ DO ❒ NP ❒ PA

Address: _____ Phone: (_____)_____

Healthcare Provider (MD, DO, NP, PA) Facility Stamp **(REQUIRED)**:

Version 2025-2026 updated 3.5.25 KM