



UNIVERSITY HEALTH SERVICES  
 2000 CLAYTON STATE BLVD.  
 STUDENT CENTER BLDG, RM 211  
 MORROW, GA 30260  
 P: 678-466-4940 F: 678-466-4944

**PHYSICAL ASSESSMENT:** (The following portion should be completed by your nurse practitioner or physician)

NAME: \_\_\_\_\_ STUDENT ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

**SECTION I: ASSESSMENT FINDINGS**

WEIGHT	HEIGHT	TEMPERATURE	VISION	PULSE	BLOOD PRESSURE	RESPIRATION
			R			
			L			

**SECTION II: (ASSESSMENT FINDINGS - CONTINUED)**

ITEM	NORMAL	ABNORMAL	EXPLAIN/COMMENT ON ABNORMAL FINDINGS
Eyes	1	1	
Ears	1	1	
Nose	1	1	
Tonsils/Mouth	1	1	
Neck	1	1	
Thyroid	1	1	
Heart	1	1	
Lungs	1	1	
Breasts	1	1	
Abdomen	1	1	
Skin	1	1	
Joints	1	1	
Lymphatics	1	1	
Musculoskeletal	1	1	
Genitalia <u>(Male/Female)</u>	1	1	<b>*Highly Recommended*</b> LNMP:                  Pap:                  Results:
Nervous System	1	1	

Additional comments / restrictions for clinical experience:

\_\_\_\_\_  
 (Signature of Nurse Practitioner or Physician)

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 Please Print Name as it appears in Signature Line)

Medical Office Stamp