

**HEALTH SERVICES
MUHLENBERG COLLEGE
ALLENTOWN, PA 18104
484-664-3199**

PHYSICIAN'S REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/her status: It will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Services and is not released without student consent

SEX: M F

LAST NAME (Print) _____ FIRST NAME _____ MIDDLE _____

B/P _____ P _____ R _____ Height _____ inches Weight _____ Lbs

*Visual Acuity

Right 20/_____ Left 20/_____ without glasses/contacts
Right 20/_____ Left 20/_____ with glasses/contacts

* Tuberculin Skin Test

or Chest X-ray: Positive _____ Negative _____

(Required within one year. Form will be returned if not completed)

Date of Testing _____

*URINALYSIS (Required): Sugar _____ Albumin _____

Minor & Major Past Surgeries (excluding dental): _____

Medications Taken Routinely: _____

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

	Yes	No
1. Head, Ears, Nose or Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Hernia		
6. Eyes		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Neuropsychiatric		
11. Skin		

NOTE: ALL ITEMS MUST BE COMPLETED.
IF NOT, FORM WILL BE RETURNED FOR COMPLETION.
CHEST X-RAY REQUIRED IF PPD IS POSITIVE.

Is there loss or seriously impaired function of any paired organ? _____ Yes _____ No

Have you any general comments?

- Recommendations for physical activity (PE, Intramurals): Unlimited _____ Limited _____ Explain:
- Is the patient now under treatment for any medical or psychological condition? Yes _____ No _____
If yes, please explain:
- Do you have any recommendations regarding the care of this student, not previously addressed? Yes _____ No _____
If yes, please explain

PHYSICIAN'S SIGNATURE _____

ADDRESS _____

TELEPHONE _____ FAX _____

PRINT PHYSICIAN NAME _____ DATE _____

Return all information to:
**DIRECTOR, COLLEGE HEALTH SERVICES
MUHLENBERG COLLEGE
ALLENTOWN, PA 18104**