ITHACA COLLEGE
Hammond Health Center

PHYSICAL EXAM

TO BE COMPLETED BY YOUR PHYSICIAN OR HEALTH CARE PROFESSIONAL

Please complete the form below or send a copy of a complete physical exam done within the past year.

Patient Name:_____ **DOB:**_____

Past Medical/Surgical History:_____

_____

_____

Medications **(please list any medications the patient is currently taking):** 1)_____

2)_____ 3)_____

4)_____ 5)_____

Allergies **(please list any known allergies or adverse reactions):** 1)_____

2)_____ 3)_____

DATE OF PHYSICAL EXAM **(MM/DD/YYYY):**_____

Height:_____ **Weight:**_____ **BP:**_____ **Pulse:**_____

	Normal	Abnormal	Comments
Skin	☐	☐	
HEENT	☐	☐	
Neck/Thyroid	☐	☐	
Lymph nodes	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Musculoskeletal	☐	☐	
Other			

List all current medical and mental health issues

1)_____

2)_____

3)_____

Recommendations for continuing care

1)_____

2)_____

3)_____

Please attach or forward any medical records that may be needed in order to provide appropriate care to this student while they are at college. ***Mail records to: Hammond Health Center, Ithaca College, 953 Danby Rd., Ithaca, N.Y. 14850 ATTN: Medical Director OR fax to: (607)274-1844.*** *If the student will need continuing care for a medical issue, please instruct them to contact the Ithaca College Health Center for an appointment. We cannot automatically assume responsibility for a student's care without their willing participation.*

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Certifying signature: _____ **Date:**_____

Name of physician or health care facility:_____

Street: _____City:_____State _____Zip _____

Phone #:_____Fax #:_____