Indiana State University
Coordinated Program in Dietetics
Student Physical Form

Last name: _____ First Name:_____Student ID #_____
History: Have there been any serious illnesses or injury that might affect your present health status? Yes or No. If Yes, please explain: _____
_____
Physical Examination: Date of Birth ____/____/____ Ht.:_____ Wt.:_____ B/P____
Resting heart rate/regularity_____ Vision (with correction) R_____ L_____
Hearing R_____ L_____

System	Normal	Abnormal (please explain
Head, Face, Neck, Scalp		
Nose and sinuses		
Mouth, teeth, throat		
Ears and eardrums		
Chest and lungs		
Heart/vascular system		
Abdomen, viscera, hernia		
Anus and rectum		
Endocrine system		
Genitourinary system		
Upper extremities		
Lower extremities, feet		
Spine, other musculoskeletal		
Skin and lymph nodes		
Neurological		
Identifying body marks		
TESTS	Date	Results
Urine: Sugar		
Protein		
IMMUNIZATIONS	Dates:	
Measles, Mumps, Rubella		
Diphtheria and Tetanus		
Varicella (2 injections or titer results)		
Hepatitis #1		
#2		
#3		
Two step TB Test – 30 days apart	Date Given: Date Read: Date Given: Date Read:	 Results (mm): Results (mm):

Signature of Health Care Provider/Date_____

Address:_____ Phone #_____

(Signature confirms that immunization information is correct.) Date:_____