Virginia Tech Carilion School of Medicine
Physical Examination Form
C O N F I D E N T I A L

A physical examination is required and must be completed and signed by appropriate personnel

Last Name	First Name	Middle Name	Date of Birth (month/day/year)	
Permanent Address	City	State	Zip Code	Area Code/Phone Number
Height _____	Weight _____			BP _____/_____

	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Musculoskeletal			
7. Neuropsychiatric			
8. Skin			

A. Is there loss or seriously impaired function of any paired organs? Yes ___ No___
Explain _____

B. Is student under treatment for any medical, physical, or emotional condition? Yes ___ No___
Explain _____

C. Is there any limitation for physical activity or physical concern that could preclude the student from successfully completing medical school? Yes ___ No____
Explain _____

D. In your opinion, is this student physically and emotionally healthy? Yes ___ No___
Explain _____

E. Other medical, physical, or psychological conditions that you believe we should be aware of?

Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in the activities of a health professional in a clinical setting. (Date) Yes ____ No ____

If no, please explain _____

_____ _____
Signature of Physician/Physician Assistant/ Nurse Practitioner Date

_____ _____
Print name of Physician/Physician Assistant/ Nurse Practitioner Area Code/Phone Number

_____ _____ _____ _____
Office Address City State Zip Code