Wheeling University ◆ Doctor of Physical Therapy Program

ANNUAL PHYSICAL FORM

YOUR PHYSICIAN OR NURSE PRACTITIONER MUST COMPLETE, SIGN, AND DATE THIS FORM.

PLEASE PRINT
STUDENT NAME: ______________________ ______________________ __________ DATE OF BIRTH: ______________
Last First Middle Initial

Family history:
Among your immediate relatives (parents, siblings and grandparents), is there any history of, or present illness from, any of the following:

- ❑ Cancer
- ❑ Diabetes
- ❑ Asthma, Hay Fever, or other Allergies
- ❑ Heart Disease
- ❑ Marfan's Disease
- ❑ Sudden death under age 50 from non-trauma cause

Please explain any of the marked replies: ____

Height:__________________Weight:___________________Blood Pressure:_____________________Pulse: ___________________

LIST MEDICATIONS: ____

Normal		Abnormal	Notes of Abnormality
________	Skin	________	
________	Hearing	________	
________	Head	________	
________	Ear, Nose, & Throat	________	
________	Neck: Thyroid	________	
________	Cardiovascular	________	
________	Lungs	________	
________	Breasts	________	
________	Abdomen	________	
________	Genitalia	________	
________	Menstruation	________	
________	Back & Extremities	________	
________	Reflexes	________	

________Student must be able to lift up to 50 pounds. Does this student meet this qualification? ____________

ALLERGIES/REACTIONS: No known allergies: ________
Latex:____food: ____

dyes:____medication: ____

(REQUIRED RESPONSE) Does this student have any past or current physical or emotional conditions that you consider important?

____

(REQUIRED RESPONSE) Is this student presently under medical therapy or psychological counseling?

____

Recommendations: ____

Name of Physician OR NP (print): ____

Phone: [______]________________________ Fax: [______]____________________

Address: (Street)____________________(City)________________(State)____(Zip) ______

Signature of Physician OR NP:_____________________________________Date: ______________

Revised 03/12/2020