HEALTH EVALUATION

University of Iowa Student Health Service*

Students following a health science curriculum must have this form completed by their physician and returned to the Student Health Service. Immunization information must be included. Please read our Immunization Form for immunization requirements and information.

-Label-

Today's Date: ________________

Name: (please print) ____
(last) (first) (middle) (student ID #) date of birth

Preferred name if different from above: ____

ADMISSION: to college of ☐ Dentistry; ☐ Medicine; ☐ Nursing; ☐ Pharmacy; ☐ Public Health; ☐ other (specify):______________

Sex: ☐ male ☐ female ☐ Other _______________________ **Blood Pressure:** _______/_______ **Pulse Rate:** ________________

Corrected Vision: right eye—20/________ left eye—20/________ **Height** ___________ **Weight** ______________

Medications____ **Allergies** ____

____ ____

Review of Systems Are there any abnormalities in the following organ systems? **N/A=Not applicable or not done**

System	Yes	No	N/A	Comment	System	Yes	No	N/A	Comment
Eyes					Integumentary				
Ear/Nose/Mouth/Throat					Neurologic				
Cardiovascular					Psychiatric				
Respiratory					Endocrine				
Gastrointestinal					Heme/Lymph				
Genitourinary					Allergic/Immunologic				
Musculoskeletal					"All others negative"				

Physical Exam Nl=normal; Abn=abnormal; N/A=Not applicable or not done

Eyes	**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Inspection of conjunctivae/lids				
Exam of pupils/irises				
Ophthalmic exam of optic discs/posterior seg.				
Ears, Nose, Mouth, Throat	**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
External inspection or ears/nose				
Otoscopic exam of external canals/TM's				
Assessment of hearing				
Inspection of lips/teeth/gums				
Inspection of nasal mucosa/septum/turbinates				
Inspection of oropharynx				
Neck	**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Exam of neck				
Exam of thyroid				
Cardiovascular	**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Auscultation of heart (note abnormal heart sounds)				
Exam of carotid arteries				
Exam of abdominal aorta				
Exam of femoral arteries				
Exam of pedal pulses				
Exam of extremities for edema/varicosities				
Respiratory	**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Assessment of respiratory effort				
Percussion of chest				
Palpation of chest				
Auscultation of lungs				
Lymph Nodes	**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Neck				
Axillae				
Groin				
Other				
Gastrointestinal	**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Exam of abdomen (note masses/tenderness)				
Exam of liver/spleen				
Exam for hernia				
Exam of anus/perineum/rectum				
Stool sample for occult blood (if indicated)				

[Patient label goes here] or

Patient's Name____

Student ID#__________________ Date of Birth______________ Age______

Preferred Name if different from above: ________________________________

Chest (Breasts)		**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Inspection of breasts					
Palpation of breasts/axillae					
Genitourinary		**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Scrotal Contents	External genitalia				
Penis	Urethra				
Rectal Exam/prostate	Bladder				
	Cervix/Uterus				
	Adnexa/parametria				
Musculoskeletal		**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Exam of gait and station					
Inspection and/or palpation of digit(s)/nail(s)					
Exam of joints, bones, muscles of one or more of (circle areas examined): 1) Head/neck 2) Spine/ribs/pelvis 3) RUE 4) LUE 5) RLE 6) LLE					
•Inspection/palpation for misalignment, asymmetry, crepitus, defects, tenderness, masses, effusions					
•Range of motion, noting pain, crepitus, contracture					
•Assessment of stability with notation of any dislocation, crepitus, or contracture					
•Assessment of muscle strength/tone with notation of atrophy or abnormal movements					
Integumentary		**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Inspection of skin and subcutaneous tissue					
Palpation of skin and subcutaneous tissue					
Neurologic		**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Test cranial nerves with notation of deficits					
Exam of deep tendon reflexes/ pathologic reflexes					
Cerebellar testing					
Exam of sensation					
Psychiatric		**Nl**	**Abn**	**N/A**	**Comments, note any abnormalities**
Orientation to time, place, and person					
Recent and remote memory					
Mood and affect					

Other:

Impression:

Plan:

Verification:

____

Examiner's signature Degree Date

____

Print name

____

Street Address City State Zip Telephone

Return this form to: Student Health Service, The University of Iowa, 4189 Westlawn, Iowa City, IA 52242-1100 or Fax to: 319-335-7247