

**OHIO UNIVERSITY SCHOOL OF PHYSICAL THERAPY
MEDICAL REPORT**

Student's Name _____ SSN _____

Address _____ City/State _____

Age _____ Sex _____ Height _____ Weight _____

MEDICAL HISTORY

Do you have or have you had:

Diabetes	Yes	No	Vision Problem	Yes	No
Tuberculosis	Yes	No	Hearing Problem	Yes	No
Heart Disease	Yes	No	Asthma	Yes	No
Back Injury	Yes	No	High Blood Pressure	Yes	No
Speech Defect	Yes	No	Dizziness/Fainting	Yes	No
Hernia	Yes	No	Convulsions/Epilepsy	Yes	No
Head Injury	Yes	No	Nervous Disorders	Yes	No
Syphilis	Yes	No	Mental Illness	Yes	No
Do you take any medications or drugs:	Yes	No	Other Chronic Diseases/ Or Defects	Yes	No
Alcoholism/Drug Addiction	Yes	No			

Comments: _____

Student's Signature _____

PHYSICAL EXAMINATION

Blood Pressure _____ Height _____ Weight _____

Nose and Throat _____

Eyes _____ Vision _____ Satisfactory _____ Corrected _____ Needs further eval _____

Ears R _____ L _____ Hearing: Normal _____ Abnormal _____

Chest _____

Heart _____

Abdomen _____

Extremities _____

Spine _____

Neurological _____

Skin _____

Comments on Abnormal Findings: _____

Communicable Disease: I certify that no communicable disease is evident at the time of this examination.

Physician's Signature _____

Date _____