UNIVERSITY OF THE INCARNATE WORD
SCHOOL of OSTEOPATHIC MEDICINE

University of Incarnate Word
School of Osteopathic Medicine

SENTRY MD

PART V PHYSICAL EXAM | *The following form completed, signed and stamped your healthcare provider.* ***REPEAT ANNUALY.***

Last Name:	**First Name:**	**Date of Birth:**

The information contained in this form will be used only by the UIWSOM for purposes of determining if a health threat/risk is posed for students or patients during clinical experiences, rotations, or clerkships. This information will remain as part of the secured student file in and will always remain confidential. The program recommends an annual updated medical history, immunizations, and physical examination, but requires the forms be updated if any health status issues changes in the interim.

Student Signature: _____

To be completed and signed by healthcare provider

Height (inches): ____ Weight (pounds): ____ BP:____/____ Pulse:____ Vision: Right: 20/____ Left: 20/____

Enter "NE" if not evaluated

Medical	Normal	Abnormal	Give details of each abnormality
Head, Neck, Face, and Scalp			
Nose and Sinuses			
Mouth, Teeth, Gingiva, and Throat			
Ears – General (canals, drums, etc.)			
Eyes – General (lids, pupils, motions, etc.)			
Lungs, chest, and breasts			
Heart (include estimate of cardiac function)			
Vascular System (include varicosities)			
Abdomen and Viscera (include hernia)			
Anorectal and Pilonidal			
Endocrine System			
Genito-Urinary System			
Upper Extremities			
Lower Extremities			
Spine and Musculoskeletal			
Skin and Lymphatic (include acne)			
Neurological System			
Psychiatric/Behavioral Health			

Are there any conditions, physical and/or emotional, which may interfere with functioning as a health professional student in the classroom or clinic? (Circle one) No Yes

If yes, please describe:_____

Any allergies to medications? (Circle one) No Yes

If yes, please describe:_____

Primary Care Provider Signature AND Provider's stamp is required on this form to be accepted.

PLACE PROVIDER'S STAMP HERE

_____

Provider's Signature *Date*

Provider Name (printed): _____

Phone Number: (____) _____