PHYSICAL EXAM To be completed by a Health Care Provider

*****Please attach copy of insurance card*

Name: ____ **Date of Birth:** ___________
Sex ☐ Male ☐ Female **Gender** __________ **Bronc ID** _______________________
Home Address: ____
City: _______________________ **State:** _________ **Zip code:** ________ **Country:** ______________
Home Telephone: ( ) ______________ **Student cell:** ( ) _____________
Campus ☐ Lawrenceville ☐ Princeton **Starting Term**: ☐ Fall ☐ Spring Year_______ Freshman ☐ Transfer ☐

EMERGENCY CONTACT
Name: ____ **Relationship to you:** ________________
Home: ( ) ________________ **Cell:** ( ) ________________ **Work:** ( ) __________________

Weight ___________ Height _____________ Blood pressure ______________
Allergies: ☐ Medications __________________ ☐ Food/environmental/insects __________________ ☐ None

Medical Conditions ____

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Previous hospitalizations or operations: ____

Daily Medications (including prescriptions, over the counter, birth control, vitamins) (attach additional page if necessary)

Medication	Dosage	Frequency

EXAM

SYSTEM	Normal	Abnormal	Description in detail
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			
Skin			

Date of Examination: __________
Provider's Name & Address: ____________________________

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Telephone Number: ( ) __________________
Provider's Signature: ____________________________

Provider Stamp Required