# Health Form and Physical Exam

## Health Sciences

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**Due:** August 1st

Submit form by:

**Email:** yhmedicalrecords@yale.edu (preferred)

Mail: P.O. Box 208237, New Haven, CT 06520

Fax: 203-436-5536

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### Last Name | First Name | Date of Birth | Sex assigned at birth: | Gender Identity:
---|---|---|---|---

### E-mail | Student Cell Phone | Sex assigned at birth: | Gender Identity:

### Home Address (include city and state) | Parent/Guardian Home Phone | Parent/Guardian Work Phone

### Emergency Contact Name | Relationship | Emergency Contact Phone

### Department or School (e.g., MD, PA, NP, etc.)

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## Physical Examination

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Blood Pressure</th>
<th>Pulse</th>
</tr>
</thead>
</table>

### Allergies to medications?  Yes  No  *(If yes, please list)*

### Severe food allergy?  Yes  No  *(If yes, please list)*

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If this patient receives allergy immunotherapy please complete the Student Allergy Medical Treatment Plan form.

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### Current or past medical, surgical, or psychiatric condition(s).  Please list and include relevant medical information:

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### Prescription medication(s)  Please list and include dosage:

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### Vitamins, supplements and over-the-counter medications taken regularly  Please list:

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This is a pre-entrance requirement and cannot be completed at Yale Health.

Health Form and Physical Exam

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth: <em><strong>/</strong></em>/____</th>
<th>Month Day Year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Clinical Evaluation</th>
<th>Normal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No: Details</td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, ears, eyes, nose, throat, hearing and visual acuity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth, teeth and gums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck and thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs/Chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breasts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart (supine and upright)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back/Spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities/Musculoskeletal/Femoral Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/Psychological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other findings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have reviewed the medical history and examined the student noted above; the information is accurate and complete to the best of my knowledge. The student is cleared medically and psychologically to participate in the demands of college life.

☐ Yes/Unlimited activity and fit for college ☐ No/Limited activity

Reason: ____________________________________________________________

Recommendations: ____________________________________________________

<table>
<thead>
<tr>
<th>Signature of Healthcare Provider (Parent or guardian cannot sign as the healthcare provider)</th>
<th>Date</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Name of Healthcare Provider</th>
<th>Address (include city and state)</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Rev. 4/6/23