Yale HEALTH

Health Form and Physical Exam

Due: **August 1st**

Submit form by:
Email: yhmedicalrecords@yale.edu (preferred)
Mail: P.O. Box 208237, New Haven, CT 06520
Fax: 203-436- 5536

Last Name	**Legal First Name**	**Date of Birth** ____/____/____ Month Day Year	
Chosen Name	**Sex Assigned at Birth**	**Gender Identity**	**Pronouns**
E-mail		**Student Cell Phone**	
Home Address (include city and state)	**Parent/Guardian Home Phone**	**Parent/Guardian Work Phone**	
Emergency Contact Name	**Relationship**	**Emergency Contact Phone**	
Department or School			

Physical Examination | To be completed and signed by your healthcare provider

Height	**Weight**		**Blood Pressure**	**Pulse**

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

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

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

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

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

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

FOR OFFICE USE ONLY

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

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Last Name	**First Name**	**Date of Birth:** ____/____/____ Month Day Year

Clinical Evaluation	**Normal**	**Abnormal**	**Comments**
Skin			
Head, ears, eyes, nose, throat, hearing and visual acuity			
Mouth, teeth and gums			
Neck and thyroid			
Lungs/Chest			
Breasts			
Heart (supine and upright)			
Abdomen			
Genitalia			
Back/Spine			
Extremities/Musculoskeletal/Femoral Pulses			
Neurologic			
Emotional/Psychological			
Other findings			

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:

Signature of Healthcare Provider *(Parent or guardian cannot sign as the healthcare provider)*	**Date**	**Phone**

Print Name of Healthcare Provider	**Address (include city and state)**	**Fax**

Rev. 12/14/2023