INDIANA UNIVERSITY
**SCHOOL OF NURSING**
IUPUC

# PRE-ADMISSION PHYSICAL EXAMINATION FORM

This is a confidential form that must be filled out by the student and his/her primary care provider. The student will not be fully admitted and enrolled until all pages of this form are completed, signed and returned.

Student Name: _____ Student ID: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Country: _____

| Physical Environment | Can Perform | Cannot Perform | Please list assistive devices needed or other comments: |
|---|---|---|---|
| Lifting up to 50 lbs without assistance | ☐ | ☐ | |
| Carrying up to 50 lbs without assistance | ☐ | ☐ | |
| Fine motor skills of all fingers and both hands | ☐ | ☐ | |
| Unrestricted movement of both lower extremities; neck, shoulders, back, and hips | ☐ | ☐ | |
| Walking | ☐ | ☐ | |
| Standing up to 8 hours | ☐ | ☐ | |
| Sitting up to 4 hours | ☐ | ☐ | |
| Twisting at the waist | ☐ | ☐ | |
| Kneeling | ☐ | ☐ | |
| Climbing | ☐ | ☐ | |
| Squatting | ☐ | ☐ | |
| Reaching above shoulders | ☐ | ☐ | |
| Smelling (able to detect odors) | ☐ | ☐ | |
| Touching (temperature and vibratory sense) | ☐ | ☐ | |
| Speaks English clearly | ☐ | ☐ | |

| Hearing | Normal | Abnormal | Please list assistive devices needed or other comments: |
|---|---|---|---|
| Hear normal speaking level sounds (person-to-person) | □ | □ | |
| Hear faint voices | □ | □ | |
| Hear faint body sounds (blood pressures, lung sounds, heart sounds, placement of tubes) | □ | □ | |
| Hear in situations when not able to see mouth (when masks are being used) | □ | □ | |
| Hear alarms (monitors, fire alarms, code alarms, call light) | □ | □ | |

| Vision | Normal | Abnormal | Please list assistive devices needed or other comments: |
|---|---|---|---|
| Able to distinguish shades of color | □ | □ | |
| Vision 20-20 without correction | □ | □ | |
| Vision 20-20 with correction. | □ | □ | |
| Depth perception WNL | □ | □ | |

Is this patient taking any medications that could result in a positive drug screen? □Yes □No
If yes, explain:_____

To your knowledge, does this patient have any significant medical problems? □Yes □No
If yes, explain:_____

To your knowledge, does this patient have any emotional, psychological or psychiatric problems?
□Yes □No
If yes, explain:_____

Physician/NP/PA Name and license number:_____
Phone: (____)_____
Address:_____
City:_____ State:_____ Zip:_____
Country:_____
Physician/HP/PA Signature:_____
Date:_____