



IUPUC
DIVISION OF HEALTH SCIENCES

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	<input type="checkbox"/>	<input type="checkbox"/>	
Carrying up to 50 lbs without assistance	<input type="checkbox"/>	<input type="checkbox"/>	
Fine motor skills of all fingers and both hands	<input type="checkbox"/>	<input type="checkbox"/>	
Unrestricted movement of both lower extremities; neck, shoulders, back, and hips	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	
Standing up to 8 hours	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting up to 4 hours	<input type="checkbox"/>	<input type="checkbox"/>	
Twisting at the waist	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	
Smelling (able to detect odors)	<input type="checkbox"/>	<input type="checkbox"/>	
Touching (temperature and vibratory sense)	<input type="checkbox"/>	<input type="checkbox"/>	
Speaks English clearly	<input type="checkbox"/>	<input type="checkbox"/>	

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

Vision	Normal	Abnormal	Please list assistive devices needed or other comments:
Able to distinguish shades of color	<input type="checkbox"/>	<input type="checkbox"/>	
Vision 20-20 without correction	<input type="checkbox"/>	<input type="checkbox"/>	
Vision 20-20 with correction.	<input type="checkbox"/>	<input type="checkbox"/>	
Depth perception WNL	<input type="checkbox"/>	<input type="checkbox"/>	

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: _____