WVU DIVISION OF PHYSICAL THERAPY – HEALTH INFORMATION FORM

Click To Clear Form

Student: Please fill out **ALL FIELDS** (typed), print a copy, and sign below. **Form must be scanned and uploaded before May 31, 2018.**

Name: _____ DOB: _____ Age: _____

Medical History	
Allergies	
Operations (date/reason)	
Medical/Emotional problems requiring treatment (past or present)	
Medications	

Family History		
Family Member	**Age(s)**	**State of Health (indicate if deceased)**
Father		
Mother		
Brother(s)		
Sister(s)		
Spouse		
Children		

Your current health status: _____

Comments or additional history: _____

*To my knowledge, the medical history information I have provided is **accurate** and **complete**. I give permission to appropriate officials of the WVU School of Medicine to release the necessary parts of my health forms, including immunization records and titer results, when required for clinical rotations as well as rotations on and off campus to which I make applications.*

Student Signature: _____ Date: _____

***Revised January 2016*

WVU DIVISION OF PHYSICAL THERAPY – PHYSICAL EXAMINATION FORM

Qualifying healthcare provider: Please fill out **ALL FIELDS** and sign below.

Student: Physical exam must have been completed after February 1, 2016. **Form must be scanned and uploaded before May 31, 2018**

Name: _____ DOB: _____ Height: _____ Weight: _____ Pulse: _____ BP: _____

	Normal	Abnormal	Comment
Vision OD 20/ **Vision OS 20/**			**With or Without Corrective Lenses – circle one**
Hearing			**[Mandatory]**
Ishihara Color Vision			**[Mandatory]**
HEENT			
Neck			
Chest			
Lungs			
Heart			
Abdomen			
Genitalia			
Extremities			
Musculo/Skeletal			
Psychological			

Summary of medical problems/concerns:_____

_____

_____

Health Care Provider Name (printed):_____ Signature: _____ Date: _____

***Revised January 2016*