Augustana University – Department of Nursing
Norwegian Nursing Exchange Program – PHYSICAL EXAM FORM

This form is to be completed by a physician, nurse practitioner or physician's assistant.

Name _____

PHYSICAL EXAMINATION

Height (without shoes _____ Pulse _____

Weight _____ Blood Pressure _____

CLINICAL EVALUATION (Please place a checkmark in the appropriate column)	**Normal**	**Abnormal**	**Comments/Recommendations**
Skull, Scalp, Face, Neck, Thyroid			
Ears			
Nose and Sinuses			
Mouth, Throat, Tonsils			
Teeth ( ) Fillings, ( ) Dentures			
Eyes R-20/___, L-20/___ Correction			
Lungs			
Heart (rhythm, sounds, murmurs)			
Abdomen			
Spine, other musculoskeletal			
Extremities			
Skin			
Neurologic			
Psychiatric (personality deviations)			

FAMILY HISTORY		Have you or any of your relatives had any of the following:					
AILMENT	**YES**	**NO**	**RELATIONSHIP**	**AILMENT**	**YES**	**NO**	**RELATIONSHIP**
Tuberculosis				Diabetes			
Kidney Disease				Heart Disease			
Arthritis				Stomach Disease			
Asthma/Hayfever				Mental Health Disorder			
Seizure Disorder				Cancer			

Any known allergies or chronic medical conditions (e.g. latex allergy, medication allergy, asthma, diabetes, etc.)?

Signature of Health Professional Providing this Evaluation & Documentation _____

Clinic Name and Address _____

Date _____