

**Augustana College – 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 _____

<u>CLINICAL EVALUATION</u> (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 _____