THE UNIVERSITY OF RHODE ISLAND
DIVISION OF STUDENT AFFAIRS

PHYSICAL EXAMINATION

UPLOAD THIS FORM IN THE PATIENT PORTAL BY VISITING: HEALTH.URI.EDU

THINK BIG WE DO

DR. PAULINE B. WOOD HEALTH SERVICES
6 Butterfield Road, Potter Building, Kingston, RI 02881 USA p: 401.874.2246 f: 401.874.2586 http://health.uri.edu

To Student's Physician: We would appreciate completion and your signature.

If you have any questions regarding our services, please call (401) 874-2246.

**** Use of this form is not required; your provider may copy their form if previous exam was within 18 months.***

STUDENT NAME: _____ **DATE OF BIRTH:** _____
(Please print) Last Name First Name MI

Weight: _____ Height: _____ BP: _____ Pulse: _____ Respiration: _____

PHYSICAL EXAM: ☐ NORMAL ☐ ABNORMAL

IDENTIFY ABNORMALS:

IMPRESSION (diagnoses, recommendations, restrictions).
Please note any health problem, chronic health condition or disability that may affect behavior or health of the student while at college.

ALLERGIES *(Please list **ALL** allergies to medications, foods and other miscellaneous items)*

MEDICATION ALLERGIES:	
FOOD ALLERGIES:	
OTHER ALLERGIES:	☐ BEES ☐ LATEX ☐ NUTS ☐ SEASONAL / POLLEN

MEDICATIONS *(Include prescriptions, over-the-counter, and herbal)*

NAME	DOSE	FREQUENCY	RELATED DIAGNOSIS

PROVIDER SIGNATURE: _____ **DATE OF EXAMINATION:** _____

PROVIDER NAME: _____ **PHONE:** _____ **FAX:** _____

ADDRESS: _____