

**EMBRY-RIDDLE UNIVERSITY**  
**PHYSICAL EXAMINATION**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ PULSE \_\_\_\_\_

Left BP 1) \_\_\_\_ / \_\_\_\_ 2) \_\_\_\_ / \_\_\_\_ 3) \_\_\_\_ / \_\_\_\_  
Right BP 1) \_\_\_\_ / \_\_\_\_ 2) \_\_\_\_ / \_\_\_\_ 3) \_\_\_\_ / \_\_\_\_

CORRECTED VISION (CONTACTS): Y / N

VISION: R 20/ \_\_\_\_ L 20/ \_\_\_\_

**PHYSICAL EXAMINATION**

<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>INITIALS</b>
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Heart			
Pulses			
-Femoral to exclude aortic coarctation			
- R radial pulse compared to femoral pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Physical stigmata of Marfan syndrome			

<b>MUSCULOSKELETAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>INITIALS</b>
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			

**CLEARANCE**

Cleared ----- YES / NO

Reason not cleared: \_\_\_\_\_

\_\_\_\_\_

Cleared after completing evaluation / rehabilitation for: \_\_\_\_\_

Name of Physician (print) \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_