



TEXAS A&M INTERNATIONAL UNIVERSITY  
COLLEGE OF NURSING AND HEALTH SCIENCES  
DR. F.M. CANSECO SCHOOL OF NURSING

Physical Examination Form

Name: \_\_\_\_\_ Student ID: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ B/P: \_\_\_\_\_

Physical Examination	No Limitations Noted	Other (Please describe)
1. Past Medical History	<input type="checkbox"/>	_____
2. Eyes, Ears, Nose, Throat	<input type="checkbox"/>	_____
3. Heart	<input type="checkbox"/>	_____
4. Lungs/ Thorax	<input type="checkbox"/>	_____
5. Abdomen	<input type="checkbox"/>	_____
6. Extremities	<input type="checkbox"/>	_____
7. Spinal Column	<input type="checkbox"/>	_____
8. Neuro	<input type="checkbox"/>	_____
9. Skin	<input type="checkbox"/>	_____

*I certify that I have examined this student and he/she is in good health and has no restrictions which would interfere with performance of student nursing functions.*

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date