GENESEO
THE STATE UNIVERSITY OF NEW YORK

Department of Student Health and Counseling

PHYSICAL EVALUATION

The Department of Student Health and Counseling (SHC) at SUNY Geneseo has received Accreditation as a MEDICAL HOME. A MEDICAL HOME is student-centered, comprehensive, team-based, accessible, and quality focused. Allow us to be part of your health care team. We need your detailed health history, recent physical exam, and immunization records in order to coordinate with your health care providers to offer the best medical care. Student Health and Counseling, your "MEDICAL HOME Away From Home."

Patient to complete this box:

Name: ______________________________________ DOB:_____________ Geneseo ID Number: G00_________________

Phone #: ______________________________ Email:____________________________________

BP _____________ **HR** ___________ **RR** ________

Height: ____ feet ____inches **BMI** _______

Weight: ______ pounds **Waist Circumference** ______

Vision: Uncorrected or Corrected:

OD ________ OS ________ OU ________

ALLERGIES (medications, food, latex, other):

____

____

Medications (Including Birth Control, IUD, monthly injections, Psychiatric medications):

____

____

____

Clinical Evaluation – Describe each abnormality or history (ex. Asthma, ITP, cardiac, etc.) in the space provided or in the comments section on page 2

Enter N/A if not evaluated	NORMAL √	ABNORMAL FINDINGS
Head, Neck Face and Scalp		
Nose and Sinuses		
Mouth and Throat		
Ears (perf of drum, etc.)		
Eyes (lids, conjunctiva, etc.)		
Pupils and Ocular Motion		
Lungs		
Heart		
Vascular System (varicosities, etc.)		
Abdomen and Viscera (include hernia)		
Breasts / Pelvic Exam		
Endocrine System		
G-U Male		
Upper Extremities (strength, range of motion)		
Lower Extremities (as for upper)		
Spine, other Musculo-Skeletal		
Skin and Lymphatics		
Neurologic		

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Patient to complete this box:

Name: ____ DOB:_____________ Geneseo ID Number: G00_______________

Mental Health: ☐ Anxiety ☐ Depression ☐ Other:

COMMENTS:

Please read carefully and respond to the following. There is space below for comments.

1.	☐ Yes	☐ No	Does this patient have any newly diagnosed conditions OR a health issue that is currently being studied/is pending? **(If yes, comment below, or attach summary)**
2.	☐ Yes	☐ No	Is there loss or seriously impaired function of any paired organ? **(If yes, comment below)**
3.	☐ Yes	☐ No	Upon completion of a complete physical examination, I have found this student capable of participating in a full program of college study, including participation in intercollegiate sports.

COMMENTS:

Must be signed by Physician, NP, or PA:	**PRINT or STAMP information below**
Exam Date: ______________ **MONTH/DAY/YEAR**	**Provider Name:** ______________________________
Today's Date: ______________ **MONTH/DAY/YEAR**	**Address:** ______________________________ ______________________________
Provider Signature: ______________________________	**Phone #:** ______________________________

When completed, upload to your health portal at https://myhealth.geneseo.edu

Accredited as a Medical Home by AAAHC ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Health Services Phone: 585.245.5736 Fax: 585.245.5744

Counseling Services Phone: 585.245.5716 Fax: 585.245.5071

Alcohol & Other Drug Services Phone: 585.245.5716 Fax: 585.245.5071

Health Promotion Phone: 585.245.5747 Fax: 585.245.5744