



# MISSOURI MILITARY ACADEMY

204 N. Grand Street, Mexico, MO 65265 • Ph. 573.581.1776 • Fax 573.581.0081 • info@missourimilitaryacademy.org

## PHYSICAL EXAMINATION

Student's Name \_\_\_\_\_ Date of Examination: \_\_\_\_ / \_\_\_\_ / 20 \_\_\_\_

EVALUATION: Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_

	Normal	Abnormal	Comments
Skin			
Nose			
Throat			
Teeth			
Cardiovascular			
Gastrointestinal			
Genital-Urinary			
Neurological			
Muscular Skeletal			
Scoliosis Screening			
Nutritional Status			

Please list any allergies to foods or medications \_\_\_\_\_

Please list regular/routine medications \_\_\_\_\_

1. Operations, with dates \_\_\_\_\_ Any sequelae? \_\_\_\_\_

2. Injuries, with dates \_\_\_\_\_ Any sequelae? \_\_\_\_\_

3. Any allergic condition? \_\_\_\_\_ Hay fever? \_\_\_\_\_ Asthma? \_\_\_\_\_ Eczema? \_\_\_\_\_

4. Has the boy been under a physician's care within the past two years? \_\_\_\_\_ Why? \_\_\_\_\_

5. Has the boy had a positive reaction to testing for or been treated for Acquired Immune Deficiency Syndrome or AIDS Related Complex? \_\_\_\_\_

6. Has the boy ever been in consultation with any doctor/counselor concerning emotional or psychiatric problems? \_\_\_\_\_ Hospitalized? \_\_\_\_\_ If so, describe \_\_\_\_\_

7. Has the boy ever been in consultation with a doctor/counselor concerning any controlled substance? \_\_\_\_\_ If so, describe. \_\_\_\_\_

Signature of Examining Medical Professional \_\_\_\_\_

Address \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_