University of Illinois at Springfield
Health Services

TEACHER PHYSICAL FORM

NAME _____ BIRTHDATE _____-_____-_____

(Please print) First Middle Last Month - Day - Year

TO BE COMPLETED BY EMPLOYEE:

To the best of your knowledge do you have or have you had any disease or disorder of the following:

1. Impaired health at present time?	Yes	No	14. Tuberculosis?	Yes	No
2. Heart, blood or blood vessels?	Yes	No	15. Pleurisy, asthma or emphysema?	Yes	No
3. Rheumatic fever or heart murmur?	Yes	No	16. Esophagus, stomach or intestines?	Yes	No
4. Abnormal heart rate or rhythm?	Yes	No	17. Liver or gallbladder?	Yes	No
5. High blood pressure?	Yes	No	18. Ulcer or colitis?	Yes	No
6. Diabetes or gout?	Yes	No	19. Genito-urinary system?	Yes	No
7. Thyroid or glands?	Yes	No	20. Kidneys or bladder?	Yes	No
8. Skin, muscles, bones or joints?	Yes	No	21. Brain or nervous system?	Yes	No
9. Arthritis?	Yes	No	22. Dizziness or unconsciousness?	Yes	No
10. Eyes; uncorrected visual defect?	Yes	No	23. Mental illness, epilepsy or paralysis?	Yes	No
11. Ears; impaired hearing?	Yes	No	24. Encephalitis or neuritis?	Yes	No
12. Cancer or tumor?	Yes	No	25. Alcoholism or drug use?	Yes	No
13. Lungs or bronchi?	Yes	No	26. Taking any medications?	Yes	No

LISTING BY NUMBER, DESCRIBE BELOW ALL QUESTIONS ANSWERED "YES":

Question Number	Pertinent history to include dates, severity and outcome

NAME _____

TO BE COMPLETED BY PROVIDER:

(Accepted providers include MD and NP)

Vital Signs: Height _____ in. Weight _____ lbs.

Temperature _____ Pulse _____ Respirations _____ Blood Pressure _____

Urine Dip: Description _____ Specific Gravity _____

Leukocytes _____ Nitrite _____ Protein _____ pH _____ Blood _____ Ketone _____ Glucose _____

T.B. test: _____ _____ _____ mm Negative / Positive

Date placed Date of reading Result

General Appearance	Normal / Abnormal	**REMARKS AND DETAILS OF POSITIVE / ABNORMAL FINDINGS**
Eyes	Normal / Abnormal	
Ears	Normal / Abnormal	
Nose	Normal / Abnormal	
Throat	Normal / Abnormal	
Neck	Normal / Abnormal	
Lymph Nodes	Normal / Abnormal	
Lungs	Normal / Abnormal	
Cardiovascular	Normal / Abnormal	
Reflexes	Normal / Abnormal	
Musculoskeletal	Normal / Abnormal	
Abdomen	Normal / Abnormal	
Neurological	Normal / Abnormal	
Skin	Normal / Abnormal	
Genito-urinary	Normal / Abnormal	

Do you consider applicant to be in good health? Yes / No

_____ Date of Exam

_____ Printed Name of Provider

_____ Provider's State License Number

_____ Provider's Signature

_____ Address _____ State _____ Zip Code

_____ Telephone Number _____ Fax Number