

Nightingale Healthcare Professionals

903 University Ave., Berkeley, CA 94710

L: 510.553.1800 **L**: 510.553.1818

MEDICAL EXAMINATION REPORT

STUDENT NAME:———			
S.S.#		DATE OF B	IRTH:
			rea. In some cases, only a MD may verify treatment npleted form to NHP administrative office on the first
Please Circle: MALE	FEMALE		
Date of Examination:			
HEIGHT:WEIG	HT :		
PULSE:/MIN RESP)	BLOOD PRESSUR	E:
VISUAL ACUITY: LENS: RT EYE:_LEFT EYE:_			ACUITY WITH CORRECTIVE T EYE:LEFT EYE:
CHECKLIST	NORMAL	ABNORMAL	DETAILED DESCRIPTION OF ABNORMAL FINDINGS
HANDS/SKIN			
HEAD EYES			
EAR/NOSE/THROAT/MOUTH			
NECK/NODES			
CHEST/LUNGS			
CARDIOVASCULAR			
ABDOMEN			
MUSCULOSKELETAL			
NERVOUS SYSTEM			