



Nursing Program Health Form

Student Name _____
Last First Middle Phone Number

Permanent Address _____
Street Number/Name City State Zip Code

DOB: _____

Physician Statement

PLEASE PRINT: complete this form entirely—leave no question unanswered. If a question does not apply to patient, please answer “N/A” on that line.

THIS SECTION TO BE COMPLETED BY PHYSICIAN OR PRIMARY CARE PROVIDER:

Height: _____ Weight: _____ Pulse: _____

Blood Pressure: _____ Resp: _____

Vision (Snellen): _____ / _____ R/L Corrected: Glasses Contacts

Hearing R: _____ L: _____

<u>Check line if normal:</u>	Within Normal Limits	Abnormal
<input type="checkbox"/> General Appearance	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Head & Scalp	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Face	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Skin	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> E.E.N.T.	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Neck	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Heart	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Lungs	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Breasts	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Abdomen	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Back & Spine	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Extremities	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Lymphatics	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Neurological	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Genitourinary	<input type="radio"/>	<input type="radio"/>

Physician Statement - Continued

Past illnesses: _____

Injuries: _____

Hospitalizations: _____

Personal Medical History: (Please circle all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> ADHD
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Allergies, Seasonal
<input type="checkbox"/> Anemia
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arrhythmia (irregular heart beat)
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bladder
<input type="checkbox"/> Problems/Incontinence
<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Headaches
<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> COPD/Emphysema
<input type="checkbox"/> Dementia
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes: 1 or 2
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> DVT (Blood Clot)
<input type="checkbox"/> GERD (Acid Reflux)
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Attack (MI)
<input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Lupus
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Osteopenia/Osteoporosis | <input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Peptic Ulcer
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Pulmonary Embolism (PE)
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Ulcerative Colitis |
|--|--|---|--|

Allergies to medications: _____

Allergies to other substances: _____

Medications student is presently taking: _____

Present or chronic medical problems : _____

***Is general health adequate to allow participation in a nursing education program and to perform essential duties of an RN working in a hospital, including CPR, administration of IV medication, opening of obstructed airways, catheterization, safe patient transfer/lifting, and other motor skills?** YES NO

Health Care Provider Signature: _____ Date: _____