LINFIELD SCHOOL OF NURSING: HEALTH ASSESSMENT STUDENT FORM

To be completed by student

Name_____ Date of Birth_____

Former Illnesses

No ☐ Yes ☐ If Yes, please explain:

Former Injuries

No ☐ Yes ☐ If Yes, please explain:

Former Hospitalizations

No ☐ Yes ☐ If Yes, please explain:

			Comments if applicable:
Anemia	No ☐	Yes ☐	_____
Arthritis	No ☐	Yes ☐	_____
Asthma	No ☐	Yes ☐	_____
Back Injuries	No ☐	Yes ☐	_____
Birth Defect	No ☐	Yes ☐	_____
Bladder Infections	No ☐	Yes ☐	_____
Bowel Problems	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Hearing Problems	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High B/P	No ☐	Yes ☐	_____
High Cholesterol or Lipids	No ☐	Yes ☐	_____
Infectious Mono	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Liver Disease	No ☐	Yes ☐	_____
Rheumatic Fever	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Thyroid Disease	No ☐	Yes ☐	_____
Ulcer	No ☐	Yes ☐	_____
Visual Problems	No ☐	Yes ☐	_____

Current medications:

Allergies including medications and other substances:

Present or chronic medical conditions:

Student Signature_____ Date_____

LINFIELD SCHOOL OF NURSING: HEALTH ASSESSMENT PROVIDER FORM

To be completed by provider

Name_____ Date of Birth_____

Height_____ Weight_____ Pulse_____

Blood Pressure_____ Resp_____

Vision (Snellen) / R/L Corrected / R/L
Near Vision_____

Hearing_____R_____L

Check if normal:	Comments if applicable:
☐ General Appearance	_____
☐ Head and Scalp	_____
☐ Face and Skin	_____
☐ E.E.N.T.	_____
☐ Neck	_____
☐ Heart	_____
☐ Lungs	_____
☐ Chest	_____
☐ Abdomen	_____
☐ Back and Spine	_____
☐ Extremities	_____
☐ Lymphatics	_____
☐ Neurological	_____
☐ Genitourinary	_____

Is the person seen in general health, adequate to allow participation in a nursing education program?

Yes ☐ No ☐

Comments/concerns if applicable:

Physician or Nurse Practitioner_____

Practice or Facility_____

Address_____

_____

Signature_____

Date_____

THIS INFORMATION IS CONFIDENTIAL