

LINFIELD COLLEGE SCHOOL OF NURSING: HEALTH ASSESSMENT REPORT

Name: _____

Birth date: _____

Past Illness:

Injuries:

Hospitalization:

Other: (Check if condition applies to you)

Comments

Anemia	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Back Injuries	_____	_____
Birth Defect	_____	_____
Bladder Infections	_____	_____
Bowel Problems	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Hearing Problems	_____	_____
Heart Disease	_____	_____
High B/P	_____	_____
High Cholesterol or Lipids	_____	_____
Infectious Mono	_____	_____
Kidney Disease	_____	_____
Liver Disease	_____	_____
Rheumatic Fever	_____	_____
Seizures	_____	_____
Thyroid Disease	_____	_____
Ulcer (duodenal or stomach)	_____	_____
Visual Problems	_____	_____

MEDICATIONS YOU ARE PRESENTLY TAKING:

ALLERGIES: (to medications and other substances-please list)

PRESENT OR CHRONIC MEDICAL PROBLEMS:

Student Signature _____

Date _____

LINFIELD COLLEGE SCHOOL OF NURSING: HEALTH ASSESSMENT FORM

Name _____

Birth date _____

PART II To be completed by physician or nurse practitioner

Height _____ Weight _____ Pulse _____

Blood Pressure _____ Resp _____

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

Near Vision _____

Hearing _____ R _____ L

Check if normal:

- _____ General Appearance _____
- _____ Head & Scalp _____
- _____ Face & Skin _____
- _____ E.E.N.T. _____
- _____ Neck _____
- _____ Heart _____
- _____ Lungs _____
- _____ Breasts _____
- _____ Abdomen _____
- _____ Back & Spine _____
- _____ Extremities _____
- _____ Lymphatics _____
- _____ Neurological _____
- _____ Genitourinary _____

Is general health adequate to allow participation in a nursing education program?

Name of Physician or
Nurse Practitioner _____

Address _____

Signature _____

Date _____

THIS INFORMATION IS CONFIDENTIAL