

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		

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 D Q G Scalp _____
Face D Q G Skin _____
E.E.N.T. _____
Neck _____
Heart _____
Lungs _____
Chest _____
Abdomen _____
Back D Q G Spine _____
Extremities _____
Lymphatics _____
Neurological _____
Genitourinary _____

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

< H V 1 R

Comments/concerns applicable:

Physician or Nurse Practitioner _____

Practice or Facility _____

Address _____

Signature _____

Date _____

THIS INFORMATION IS CONFIDENTIAL