LINFIELD SCHOOL OF NURSING: HEALTH ASSESSMENT STUDENT FORM To be completed by student

Nam <u>e</u>							Date of Birth	_
FormerIII	lnesæs No	Yes	If Yes	, please explain				
FormerIr	njuries No	Yes	If Yes	s, please explain	1			
FormerHospitalizations No Yes			If Yes	, please explain				
							Commentsif applicable:	
Anemia			No	Yes				
Arthritis			No	Yes				_
Asthma		NoCancer		No	Yes			

Diabetes	No	Yes
Hearing Problems	No	Yes
Heart Disease	No	Yes
High B/P	No	Yes
High Cholesterol or Lipid	sNo	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 medioadonditions

Student Signature

Date_____

LINFIELD SCHOOL OF NURSING: HEALTH ASSESSMENT PROVIDER FORM

Τо	be	comp	leted	by	provider

		10 00 00mp			
Name			Date of Birtl	<u>h</u>	
l laisht	M/aisht		Dulas		
Height	Weight		Puls <u>e</u>		
Blood Pressu <u>re</u>		Resp			
Vision (Snellen) / Near Vision	R/L	Corrected	/	R/L	
Hearing	R		L		
Check if normal:			Comments	s if applicable:	
General Appearance					
Head DQG Scalp					
Face DQG Skin					
E.E.N.T.					
Neck					
Heart					
Lungs					
Chest					
Abdomen					
Back DQG Spine					
Extremities					
Lymphatics					
Neurological					
Genitourinary					
Is the person seemin a	eneral health	n adequate to :	allow particir	pation in a nursing educa	ation program?
<pre>HV 1R</pre>					r <u>aion program</u> i
Comments/concernsta	pplicable:				
Physician or Nurse Practitioner					
Practice or Facility					
Addres <u>s</u>					
Signatur <u>e</u>					

THIS INFORMATION IS CONFIDENTIAL

Date____