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 if applicable:

Physician or Nurse Practitioner_____

Practice or Facility_____

Address_____

_____

Signature_____

Date_____

THIS INFORMATION IS CONFIDENTIAL