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

Name							Date of Birth		
FormerIII	Inesæs No	Yes	If Ye	es, please expl	ain				
FormerIn	njuries No	Yes	If Ye	es, please exp	lain				
Former Hospitalizations No Yes If Y			If Ye	es, please expl	lain				
							Commentsif applicable:		
Anemia			No	Yes					
Arthritis			No	Yes					
Asthma			NoCa	ncer	No	Yes			
Diabetes Hearing Heart Dis High B/P High Cho Infectiou Kidney Dis	Problem sease olesterol s Mono Disease sease	or Lipid	No No No	Yes Yes Yes Yes Yes Yes Yes Yes Yes					
Rheumatic Fever			No	Yes					
Seizures		No	Yes						
Thyroid Disease		No	Yes						
Ulcer Visual Problems			No	Yes					
Current r		ono	No	Yes					
Current	neulcali	0112							
Allergies	includin	gmedic	ations a	<b>d</b> other substa	ances:				
Present	or chron	ic medi	o <b>a</b> onditio	ons					
Student	Signatur	۵					Date		

## LINFIELD SCHOOL OF NURSING: HEALTH ASSESSMENT PROVIDER FORM

## To be completed by provider

Name_			Date of Birth			
Height	Weight		Pulse			
Blood Pressure	<u></u>	Res <u>p</u>		-		
Vision (Snellen) / Near Vision	R/L	Corrected	1	R/L		
Hearing	R		L			
Check if normal:  General Appearance Head DQG Scalp Face DQG Skin E.E.N.T. Neck Heart Lungs Chest Abdomen Back DQG Spine Extremities Lymphatics Neurological Genitourinary				nts if applicable:		
Is the person seenin ge < H V 1 R Comments/concernsap		h adequate to	allow partic	ipation in a nursing e	education program?	
Physician or Nurse Practitioner Practice oFacility Address				- 		
Signatur <u>e</u>				-		
Date						

THIS INFORMATION IS CONFIDENTIAL