ALVERNO COLLEGE NURSING STUDENT
Health History and Physical Examination Form

The information you are being asked to provide is being requested for two purposes. It will assist in evaluating your physical and mental capacity to perform student functions and to ascertain whether you are free from communicable disease.

The information you provide will be maintained in your school health record and is **confidential** unless authorization to disclose the information has been completed.

Completion of this record is at the student's expense.

Please upload this form to your CastleBranch account.

Name: ______________________ Date of Birth: ____________

Home Address: ______________________ Sex: Female ☐ Male ☐

City: ____________ State: ____________

Zip Code: ____________ Phone (Cell): ____________ Phone (Home): ____________

Email: ____

Father's Middle Name: ____________ City of Birth: ____________

Make/Model of First Car:

PERSONAL HISTORY
(To be completed by student)

Allergies

Drug(s): ____________ Reaction(s): ____________

Food: ____________ Reaction(s): ____________

Environmental: ____________ Reaction(s): ____________

Medications

Please list all nonprescription (over – the – counter) medications that you regularly use, including vitamins, herbal supplements, laxatives, aspirins, and weight-reducing aids:

Please list all prescription medicines that you are currently taking: ____________

Hospitalizations / Surgeries / Childbirth Within the Last Five Years	
Year	**Reason(s)**

Have you had or do you now have: (Please comment on "yes" answers as needed.)

	Yes	No		Yes	No
Heart / Blood			**Musculoskeletal**		
High Blood Pressure	☐	☐	Neck Pain / Neck Injury	☐	☐
Low Blood Pressure	☐	☐	Back Pain / Back Injury	☐	☐
Stroke	☐	☐	Spine or Joint Surgery	☐	☐
Heart Attack	☐	☐	Inability to Lift / Lifting Restrictions	☐	☐
Comments:			Dislocation of Any Joint	☐	☐
			Bone, Joint, or Other Deformity	☐	☐
Respiratory / Lungs			Fractured / Broken Bones	☐	☐
Breathing Problems	☐	☐	Joints That "Lock" or Give Out	☐	☐
Coughed Up Blood	☐	☐	Swollen / Painful Joint(s)	☐	☐
Cough Over 2 weeks Duration	☐	☐	Arthritis	☐	☐
Night Sweats	☐	☐	Fibromyalgia	☐	☐
Tuberculosis	☐	☐	Tendonitis	☐	☐
Positive TB Skin Test	☐	☐	Bursitis	☐	☐
Year:	☐	☐	Carpal Tunnel Syndrome	☐	☐
Date of Chest X-ray:			Hernia	☐	☐
INH Treatment?	☐	☐	Need to use a mobility aid (i.e., walker, cane, wheelchair, scooter)	☐	☐
Comments:			***Comments:***		
Head			**Nerve / Muscle**		
Head Injury	☐	☐	Muscular Dystrophy	☐	☐
Dizziness / Fainting	☐	☐	Parkinson's Disease	☐	☐
Headaches, Frequent or Severe	☐	☐	Paralysis	☐	☐
Comments:			Multiple Sclerosis	☐	☐
			Unusual Weakness	☐	☐
Skin			Numbness / Tingling	☐	☐
Skin Problems	☐	☐	Seizures / Epilepsy	☐	☐
Comments:			***Comments:***		

	Yes	No		Yes	No
Eyes / Ears / Nose / Throat			**Gastrointestinal**		
Wear Glasses	☐	☐	Stomach or Bowel Problems	☐	☐
Contacts (type):	☐	☐	***Comments:***		
Vision: Nearsighted	☐	☐			
Farsighted	☐	☐	**Immune System**		
Eye Problems	☐	☐	Lymph Gland Swelling	☐	☐
Hearing Problems	☐	☐	Lupus	☐	☐
Hearing Aid	☐	☐	Organ Transplant	☐	☐
Comments:			Immunocompromised	☐	☐
			Comments:		

Mental Health			
Anxiety / Panic Attacks	☐	☐	
Depression	☐	☐	
Eating Disorder	☐	☐	
Alcohol / Substance Abuse	☐	☐	
Other:	☐	☐	
Comments:			

Other Health Problems		
Cancer:	☐	☐
Chemotherapy	☐	☐
Radiation	☐	☐
Diabetes	☐	☐
Comments:		

Any other physical or psychological problem(s) not listed above:

Have you lived or traveled outside of the United States for longer than a month? Yes ☐ No ☐ If yes, when and where?

Have you had an injury to the eye involving metallic fragments, an implanted device placed (i.e., aneurysm clips, cochlear implants, pace maker, spinal cord stimulator, etc.), an injury by a metallic object (i.e., bullet, BB, shrapnel, etc.), or any other implanted metallic object? Yes ☐ No ☐ If yes, please comment:

Do you have any permanent physical, mental, or learning disabilities? Yes ☐ No ☐ If yes, what are they?

Do you have any physical, mental, or learning limitations which will require accommodation in order to allow you to perform the job duties? Yes ☐ No ☐ If so, please explain, describing any accommodation you are requesting:

I hereby declare that all statements included in this Health and Communicable Disease Record are true and correct to the best of my knowledge.

Signature of Student

Date

HEALTHCARE PRACTITIONER STATEMENT

☐ **This patient is free of clinically apparent communicable disease and current with his/her immunizations.**

As a student, this person will be assigned to provide direct patient care including patient transfers.

This student may provide patient care:

- ☐ **Without restrictions.**
- ☐ **With the following restrictions:** ______________________________
  ____
- ☐ **May not participate in clinical experience at this time.**

____
Physician, Nurse Practitioner, or Physician Assistant's name (Please print.)

____
Street Address

____
City, State, Zip

____
Telephone

____
Signature of Physician, Nurse Practitioner, or Physician Assistant

____
Date