SONOMA STATE UNIVERSITY
Department of Nursing — Health Evaluation Form

Student Name: _____ _____ Date: _____
Last First

Birthdate: _____ SSU Student ID: _____

Address: _____
Street City State Zip Code

Phone Number: ( )_____

In case of emergency, notify: _____ ( ) _____
Name Phone

PERSONAL HEALTH HISTORY

(Comment below if "YES" to any question)	Yes	No
1. Have you ever been rejected for service or employment for medical reasons:	____	____
2. Have you ever been tested for epilepsy (seizures)?	____	____
3. Have you ever been addicted to drugs or alcohol?	____	____
4. Do you have diabetes?	____	____
5. Have you ever had professional counseling for mental health problems?	____	____
6. Are you taking medications regularly?	____	____
7. Have you ever had asthma?	____	____
8. Have you ever had tuberculosis?	____	____
9. Have you had back trouble or back injuries?	____	____
10. Have you ever had any other significant medical problems not listed?	____	____
11. Do you have any special needs that will need to be accommodated in the nursing program?	____	____

Comments (Explain any "YES" answers by number)

GENERAL APPEARANCE	Normal	Abnormal	GENERAL APPEARANCE	Normal	Abnormal

Head/Eyes/Nose/Throat	Neurological
Lymph Nodes	Neck
Breasts/Chest	Upper Extremities
Heart	Lower Extremities
Lungs	Back
Abdomen	Reflexes

Please explain any abnormal history or findings:

PHYSICAL EXAMINATION

Blood pressure: _____/_____

Pulse: _____ Height (without shoes) _____ft. _____ in.

Weight (in ordinary clothes) _____ lbs. Color Vision: P F

Distance: OD 20/ _____ OS 20/_____ Corrected: OD 20/_____ OS 20/_____

Near vision: OD 20/ _____ OS 20/_____ Corrected: OD 20/_____ OS 20/_____

SUMMARY

List any medications taken regularly:

List allergies to food, medicine or other:

What recommendations have you made to this student?

_____ _____
Signature, Health Care Provider Date

_____ _____
Printed Name Telephone #

_____
Patient Name: