



STUDENT'S SSN _____

Report of Health History

The purpose of this form is to complete physical requirements for the clinical facilities utilized by Anderson University School of Nursing. I, as the student, hereby give permission for this form to remain on file in the School of Nursing and to be released to clinical sites as needed:

SIGNATURE OF NURSING STUDENT

DATE

TYPE OR PRINT IN INK

Male

Female

STUDENT'S LAST NAME

FIRST NAME

MIDDLE NAME

MAIDEN NAME

DATE OF BIRTH

STREET ADDRESS

CITY

STATE

ZIP

COUNTRY

HOME PHONE

BUSINESS PHONE

FATHER'S NAME

ADDRESS

TELEPHONE

MOTHER'S NAME

ADDRESS

TELEPHONE

SPOUSE'S NAME

ADDRESS

TELEPHONE

Personal History (to be completed by student)

Do you currently have trouble with . . . (Please check yes or no for each.)

	YES	NO		YES	NO		YES	NO		YES	NO
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Intestines	<input type="checkbox"/>	<input type="checkbox"/>	Muscles/Joints	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Nerves	<input type="checkbox"/>	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Have you . . . (Please check yes or no for each. If yes, please explain.)

	YES	NO	EXPLANATION		YES	NO	EXPLANATION
Had surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	FEMALES ONLY:			
Broken a bone	<input type="checkbox"/>	<input type="checkbox"/>	_____	Had menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____	Had breast problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a seizure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Been pregnant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had physical activity restricted during the past five years (Give reason and duration.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____				
Had any illness or injury or been hospitalized other than already noted	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____				

Have you been diagnosed with or treated for . . . (Please check yes or no for each.)

	YES	NO		YES	NO		YES	NO
Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/depression	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

List all medications you are currently taking.

MEDICATION	FREQUENCY	DOSE	MEDICATION	FREQUENCY	DOSE

List any allergies you have. (environmental, food, medication, other)

Family History (to be completed by student)

	NAME	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH
Father						
Mother						
Siblings						
Children						

Do you have any relatives who have . . . (Please check yes or no for each. If yes, list relationship to you.)

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Committed suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____

STUDENT'S SIGNATURE _____ DATE _____

PARENT / LEGAL GUARDIAN'S SIGNATURE _____ DATE _____
 Parent/legal guardian **must sign** if student is not age 18 by the beginning of Semester I.

Additional comments (details not otherwise documented on this form)

Physical Demands

The physical demands described here are representative of those that must be met by a student nurse to successfully perform the essential functions of this role. I hereby certify that this student nurse is able to perform the following functions and is free from communicable disease:

1. Student nurse is able to perform the essential functions of this role, such as physical requirements including (but not limited to) climbing stairs, the ability to lift/transfer patients and drive.
2. Student nurse is able to safely lift and physically manipulate patients.
3. Student nurse is able to participate in moderate physical activity, occasionally lifting up to 25lbs, standing, or walking for more than 4 hours per day.
4. Student nurse may be functioning in an environment that involves possible exposure to potentially dangerous materials and situations that require following safety precautions and may include use of protective equipment.

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME _____ SIGNATURE _____ DATE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTRY _____

TELEPHONE _____ FAX _____