IOWA WESTERN

The world is waiting

Medical History and Physical Examination

This page to be completed by the student:

Name:____ Male:_______ Female:_______

Home Address:____
Street City State Zip

Date of Birth:_________________________ Phone Number: _________________________

Parent/Legal Guardian:_________________________ _________________________
Name Relationship

Parent/Legal Guardian Address:____

Phone:_________________________(Home) _________________________(Work)

Family Physician:____
Name Address

Health Insurance: Yes____ No____ (If yes attach copy of insurance card)

Personal Health Information

Have you ever had or have now?

Yes	No	*Check each item on left*	Yes	No	*Check each item on left*	Yes	No	*Check each item on left*
		Arthritis			Headaches/migraines			Rheumatic fever
		Anemia			Hearing loss			Seasonal Allergies
		Asthma			Heart trouble			Stroke
		Cancer			Hepatitis			Substance abuse
		Convulsion/seizure			High blood pressure			Thyroid disorder
		Depression/psychological disorder			Kidney/bladder problems			Tuberculosis
		Diabetes			Menstrual problems			Ulcer
		Eating disorder			Multiple Sclerosis			Other:

Yes	No	
		Have you been exposed to or had any communicable diseases? If, so specify diseases, or exposure, i.e., hepatitis, TB.
		Have you ever been treated for a nervous breakdown?
		Allergy to drugs, plants, latex, etc. (list all allergies)
		Injuries (specify body location & date)
		Operations (specify & date)
		Have you visited a foreign country in the last 5 years? If so, what country?
		Have you arrived in the U.S. from a foreign country in the last 5 years? If yes, what country?
		Do you have any specialist physicians? If yes, who and for what?
		Other illness or complaints (specify)

Are you currently taking any prescription, over-the-counter, herbs or other types of medication? ________ If Yes, please specify:_________________________

____

____

All information on this physical is complete and accurate; I understand that failure to report all information accurately may result in denial of entry or dismissal from program as appropriate to the circumstances.

Signature:____ Date:_________________________

Iowa Western Department of Nursing
2700 College Rd. Council Bluffs, IA 51503
agahm@iwcc.edu | 712.325.3392 | **iwcc.edu** | Mon. – Fri. 8 AM - 5 PM

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History/Updating of Immunizations

HEPATITIS B Vaccines Vac #1 ________ Vac #2 ________ Vac #3 ________ *AND* HEPATITIS B TITERS – MANDATORY Antibody (AB) Date __________ Results __________ Antigen (AG) Date __________ Results __________	MMR Vaccine Dates Vac #1 __________ Vac #2 __________ *OR* MMR Titer Date ____________ Results __________	Optional Immunizations MENINGITIS: Date SMALL POX: Date
VARICELLA TITER (Chicken Pox) Date ____________ Results __________ *Documentation of titer result is MANDATORY. Date of injections or childhood illness dates **DO NOT APPLY.***	INFLUENZA: Seasonal influenza is required prior to clinical experience Date ______________ Lot # ______________ Sticker: Expiration Date ___________ Date ___________	***Nursing Students Only*** **Laboratory Work (attach lab copies):** Urinalysis: Protein/Sugar: Hemoglobin **A complete blood count is required with differential.** WBC: RBC: HCT:
Tdap: (Valid only if within 10 years) Date ____________	TUBERCULIN (PPD) Annually (Mantoux intradermal) — Date: — Results: *OR* Chest x-ray report *if student had previous positive TB result* — Date: — Results:	

Height: __________ Weight: __________

Distant Vision: Right 20/ Corr. To 20/ Color Vision: __________

Left 20/ Corr. To 20/

Temp.: _________ Pulse: _________ Resp. _____________ Blood Pressure _________________

CLINICAL EVALUATION:

Normal	Abnormal	Check each item in appropriate column.
		1. H E E N T
		2. LUNGS and CHEST (include Breasts)
		3. HEART
		4. ABDOMEN/hernia
		5. G-U SYSTEM
		6. MUSCULOSKELETAL
		7. SKIN, LYMPHATIC GLANDS
		8. NEUROLOGIC
		9. PSYCHIATRIC (specify any known treatment of mental illness/depression, personality disorders, etc.)
		10. To your knowledge, does this individual have a history of substance/drug abuse?
		11. Are there any physical restrictions including lifting and sports related? If yes: please describe: ______________________________________

YES	NO	N/A	
			A. Do you recommend this person for entry into a health care field with its high level of stress and responsibility?
			B. Do you consider this person capable of making health care judgments?
			C. Do you consider this person to be capable of caring for young children in a professional setting?

NOTES: Describe any abnormality:

Recommendations (for treatment, restriction of academic load, lifting, sports, etc.)

____

Examining Physician:

Signature/Date:____

Print Name:____

Address:____

City/ST/Zip:____

Phone Number:____

Office Fax Number:____

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