SOUTHERN ADVENTIST UNIVERSITY
School of Nursing

PERSONAL HEALTH ASSESSMENT & PHYSICAL EXAMINATION

Students may register for classes only after submitting a complete, official health assessment to the School of Nursing.

THIS PAGE TO BE COMPLETED BY THE STUDENT

FIRST NAME	MIDDLE	LAST (FAMILY NAME)	SOUTHERN ID NUMBER

HOME ADDRESS	BIRTH DATE MM-DD-YY	GENDER ◯Male ◯Female

CITY	STATE	ZIP CODE	BIRTHPLACE

EMERGENCY CONTACT PERSON	RELATIONSHIP	PREFERRED PHONE	ALTERNATE PHONE

ETHNIC ORIGIN

◯ Black/African American ◯ American Indian/Alaskan Native ◯ Asian
◯ Hispanic/Latino ◯ White ◯ Native Hawaiian/Other Pacific Islander

HEALTH HISTORY

Do you have a history of, or are you currently experiencing, any of the following?

◯ Yes	◯ No	Allergies	◯ Yes	◯ No	Heart disease	◯ Yes	◯ No	Ulcers
◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No	Thyroid disorders
◯ Yes	◯ No	Back problems	◯ Yes	◯ No	Hypertension	◯ Yes	◯ No	Hearing problems
◯ Yes	◯ No	Convulsions	◯ Yes	◯ No	Palpitations	◯ Yes	◯ No	Taking medications
◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Drug use
◯ Yes	◯ No	Skin disease	◯ Yes	◯ No	Kidney disease	◯ Yes	◯ No	Alcohol use
◯ Yes	◯ No	Eye disease	◯ Yes	◯ No	Migraine headaches			

FEMALES

Please indicate your last PAP date:

FAMILY HISTORY

Have your parents or grandparents had any of the following?

			RELATIONSHIP	AGE AT DEATH
◯ Yes	◯ No	Tuberculosis		
◯ Yes	◯ No	Diabetes		
◯ Yes	◯ No	Heart disease		
◯ Yes	◯ No	Hypertension		
◯ Yes	◯ No	Cancer		
◯ Yes	◯ No	Mental illness		

Healthcare professional page ☞

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PHYSICAL EXAMINATION
TO BE COMPLETED BY YOUR HEALTHCARE PROFESSIONAL

PATIENT NAME	HEIGHT	WEIGHT	B/P	PULSE

VISION		WITH GLASSES		IS DENTAL TREATMENT RECOMMENDED? If yes, please explain.
OD:	OS:	OD:	OS:	❍ Yes ❍ No

LABORATORY UNINALYSIS
Sugar: Protein: Blood:

PHYSICAL	NORMAL	ABNORMAL	NOT DONE	COMMENTS
Skin/scalp	❍	❍	❍	
Nutrition	❍	❍	❍	
Neurologic	❍	❍	❍	
Orthopedic and spine	❍	❍	❍	
Eyes	❍	❍	❍	
Visual acuity	❍	❍	❍	
Ears	❍	❍	❍	
Auditory acuity	❍	❍	❍	
Speech	❍	❍	❍	
Nose/throat/mouth	❍	❍	❍	
Teeth/gums	❍	❍	❍	
Glands, including thyroid	❍	❍	❍	
Chest, breast	❍	❍	❍	
Heart, lungs	❍	❍	❍	
Abdomen	❍	❍	❍	
Genitalia	❍	❍	❍	
Other	❍	❍	❍	

OTHER INFORMATION	YES	NO	COMMENTS
Emotional/mental behavior problems	❍	❍	
Physical handicap(s) limiting activity	❍	❍	
Restriction needed (specify degree and duration	❍	❍	
Other health problems (seizures, asthma, diabetes, sickle-cell disease, etc.)	❍	❍	

What medications or treatment is the student taking that should be continued during graduate school?

❍ Yes ❍ No I certify that I have on this date examined this person and find him/her physically and emotionally capable to perform the role of a nursing student.

HEALTHCARE PROVIDER SIGNATURE _____ PRINT NAME _____ TODAY'S DATE _____