Please Return to:
Professional Medical Careers Institute
School of Nursing
920 Hampshire Rd. Suite S
Westlake Village, Ca. 91361
FAX: 805-497-4224 PHONE: 805-497-4064

Health Assessment

PART 1.

(To be completed by Student)

Please check Program			
☐	CNA	☐	Med. Assistant
☐	LVN	☐	Psych. Tech
☐	HHA		

Student's Personal Information

NAME (Last, First, Middle Initial)_____

DATE OF BIRTH_____ **AGE:**_____ **Gender** ☐ **Female** ☐ **Male** **EMAIL:**_____

ADDRESS (Street, City, State, Zip Code):_____

HOME TELEPHONE NUMBER:_____ **MOBILE: TELEPHONE NUMBER:** _____

SOCIAL SECURITY NUMBER:_____ **DRIVER'S LICENSE NUMBER:** _____ **DLState Issued:**_____

Health Insurance Information

Insurance Company:	**Primary Insured Name:**
Group Number:	**Policy Number:**

Emergency Contact Information

NAME (First/Last)

ADDRESS (Street, City, State, Zip Code)

PRIMARY TELEPHONE NUMBER (Include Area Code)

NAME (First/Last)

ADDRESS (Street, City, State, Zip Code)

PRIMARY TELEPHONE NUMBER (Include Area Code)

Student's Personal Health History

☐ Asthma ☐ COPD	☐ Unable to use hands repetitively	☐ Heart problems	☐ Malignancy	☐ Chronic Headaches	**LIST ALL PAST MEDICAL PROBLEMS AND RELATED TREATMENTS (including operations with dates):** ☐None
☐ A.D.D. ☐ A.D.H.D.	☐ Unable to lift and carry up to 50 pounds	☐ Back Injury	☐ Severe Menstrual cramps (female)	☐ Dyslexia	**LIST ALL CURRENT MEDICAL CONDITIONS:** ☐None
☐ Chronic intestinal problems	☐ Emotional instability/ Severe Stress	☐ Kidney disease	☐ Vision problems	☐ Sleep disorder	**LIST ALL Drug and/or Food Allergy (specify):** ☐None
☐ Diabetes	☐ Epilepsy	☐ Hearing Problems	☐ Orthopedic problems	☐ Tuberculosis or TB Contact	**List Any Medications Currently Being Taken Including Dosage:** ☐None

NAME OF STUDENT/PATIENT (Last, First, Middle Initial):

1. **WEIGHT:**	2. **HEIGHT**	3. **VISION:** **OD 20/** **OS 20/** **OU 20/**	4. **HEARING:** **able to hear a forced whisper at a minimum of 5 feet?** **Left:** **Right:**
5. **PULSE:**	6. **TEMPERATURE**		
7. **RESPIRATORY RATE:**	8. **BLOOD PRESSURE:**		

9. **DOES THE PARTICIPANT HAVE ANY SIGNIFICANT FINDINGS ON PHYSICAL EXAM? (HEENT, Lymphatic, Cardiovascular, Respiratory, Abdomen, Skin, Musculoskeletal, Neurological, Psychiatric, etc.)** ☐ **YES (Specify)** ☐ **NO**

Significant Findings:

Immunizations

10. ☐ **DIPHTHERIA AND TETANUS TOXOIDS (or Diphtheria, Tetanus Toxoids and Pertussis Vaccine - DPT)**

(Vaccination Dates) _____, _____, _____, _____, _____, _____

(If Titer) Date_____ **(Value)** _____ ☐**Immune** **Pertussis Booster:**_____

11. ☐ **ORAL POLIOMYELITIS VACCINE OR** ☐ **INACTIVATED POLIO VACCINE (Dates)** _____, _____; _____

(If Titer) Date_____ **(Value)** _____ ☐**Immune** ☐**Patient was born in United States**

12a. ☐ **Primary Measles OR** ☐ **MMR immunization (dates)** _____ _____ _____

(If Measles Titer) Date_____ **(Value)** _____ ☐**Immune** **Most Recent Booster (date)** _____

12b. ☐ **MUMPS (date)** _____ **(If Titer) Date**_____ **(Value)** _____ ☐**Immune**

12c. ☐**RUBELLA (German Measles) (If Titer) Date**_____ **(Value)** _____ ☐**Immune**

13. ☐**VARICELLA (Date Chicken Pox was diagnosed):**_____ **OR Date(s) of VARIVAX VACCINE** _____,

(If Titer) Date_____ **(Value)** _____ ☐**Immune**

14. ☐ **HEPATITIS B VACCINE (date)** _____, _____, _____

(If Titer) Date_____ **(Value)** _____ ☐**Immune**

15. ☐ **COVID Vaccine 1)** _____, **2)** _____,**Boost)** _____, _____

Manufacturer:_____

16. ☐ **TB SCREENING**

a. **Tuberculin Skin Test (Date Given:**_____ **Date read:** _____ **QuantiFERON Gold:**_____

Result _____ **(Record actual mm of induration, transverse diameter, if no induration write "0")**

b. **Interpretation (based on mm of induration as well as risk factors):** ☐**Positive** ☐**Negative**
Chest x-ray (required if tuberculin skin test is positive). Result: ☐**Normal** ☐**Abnormal** **Date of x-ray:**_____

17. **Seasonal Flu Vaccine (date)** _____

18. **Drugs Screen** ***(6 panel urine)*** **Negative** _____ **Date**_____
Positive For _____

I have performed a physical examination on this patient within the past 12 months. All medical/psychiatric conditions and therapies are noted above or on attached pages. She/he may participate in the Nursing Program without restrictions. ☐

Exceptions (if any) _____ **Date:** _____

Signature: _____ **Print Name:** _____

CLINIC STAMP (required for clearance):