

ANDREWS UNIVERSITY DEPARTMENT OF NURSING

MEDICAL EVALUATION

Part 1

IDENTIFICATION Please provide the following information. All items must be completed. Please print.

Name		Date of Birth _____ / _____ / _____	
Address		Phone ()	
City	State	Zip	Cell Phone ()

EMERGENCY NOTIFICATION

Name:		Relationship	
Address:		Home Phone ()	
City	State	Zip	Work Phone ()

MEDICAL HISTORY

Please indicate which illnesses or conditions you now have or you have previously experienced. Indicate by answering yes or no. For all yes responses indicate the year of onset or occurrence.

ILLNESSES

Yes	Year	No	Yes	Year	No	Yes	Year	No	
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Rubella
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Suicide Attempt
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Vision Problem
<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	Women: Severe Period Cramps
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**ANDREWS UNIVERSITY DEPARTMENT OF NURSING
MEDICAL EVALUATION
Part 2**

Care Provider: First, review the completed medical history on the reverse side of this form, and evaluate documentation of any tests or immunizations that have already been given. Next perform the necessary tests and examinations to complete this side of the form.

Student's Name:						Age:
Ht _____	Wt _____	BP ____ / ____	Vision O.D. _____ /20	_____ Corrected	O.S. _____ /20	_____ Corrected

Examination

	Norm	Abn	Details
Skin			
HEENT			
Neck			
Heart			
Lungs			
Breast			
Abdomen			
Hernias			
Back			
Extrem			
Reflexes			

Test and Immunizations may be obtained at the County Health Department or University Medical Specialties for a fee:

Is there documentation that the following have been completed? Please give results where appropriate.

☞ Hepatitis B yes no 1st date ____/____/____ 2nd date ____/____/____ 3rd date ____/____/____

The hepatitis series is to start at the beginning of Nursing Concepts and be completed at appropriate time intervals thereafter.

☞ Chickenpox (varicella zoster) yes no Date ____/____/____ Positive varicella titer _____

☞ MMR (MR) {Adult Booster} yes no Date ____/____/____ Positive rubella titer _____ History of measles _____

☞ DT yes no Date ____/____/____ Results _____

☞ Hemoglobin (optional) yes no Date ____/____/____ Results _____

☞ TB (yearly) yes no Date ____/____/____ Results _____

If the TB skin test is positive has a CXR been performed? yes no Date ____/____/____

Results Normal Other _____

Are there any physical deformities or limitations? yes no If yes, explain _____

Are there any physical or emotional illnesses or conditions that may require ongoing medical care? yes no If yes, explain _____

Care Provider's Signature _____ **Date** ____/____/____

Print/Stamp Name _____ **Phone** (____) _____

Address _____

City _____ **State** _____ **Zip** _____