DEPARTMENT OF NURSING
MEDICAL EVALUATION
PART I

FOR OFFICE USE ONLY

MR	G	BUAL	G
TB	G	URINE	G
CXR	G	HGB	G

Student or Parent: Please provide the following information. All items must be completed. Please print.

IDENTIFICATION

Name:____ Birth Date: _____ / _____ / _____

Address:____ Phone: (______)____________________.

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EMERGENCY NOTIFICATION

Name:____ Relationship:______________

Address:____

Home Phone:(_____)_____________________ Work Phone:(_____)

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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	
G	_________	G	Anemia	G	_________	G	Gonorrhea	G	_________	G	Migraines
G	_________	G	Asthma	G	_________	G	Heart Disease	G	_________	G	Rubella
G	_________	G	Back Problem	G	_________	G	Hepatitis	G	_________	G	Suicide Attempt
G	_________	G	Bleeding Problem	G	_________	G	Hearing Problem	G	_________	G	Syphilis
G	_________	G	Cancer	G	_________	G	Herpes	G	_________	G	Thyroid Disease
G	_________	G	Colitis	G	_________	G	High Blood Pressure	G	_________	G	Tuberculosis
G	_________	G	Depression	G	_________	G	Hypoglycemia	G	_________	G	Ulcers
G	_________	G	Emotional Problem	G	_________	G	Joint Problem	G	_________	G	Vision Problem
G	_________	G	Epilepsy	G	_________	G	Measles	G	_________	G	Women: Severe Period Cramps
G	_________	G	Fainting Spells	G	_________	G	Mental Illness				

SURGERIES

Yes	Year	No		Yes	Year	No		Yes	Year	No	
G	_________	G	Appendectomy	G	_________	G	Hernia Surgery	G	_________	G	Spine Surgery
G	_________	G	Gallbladder Surgery	G	_________	G	Knee	G	_________	G	Thyroid Surgery
G	_________	G	Others (Explain								

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HOSPITALIZATIONS: List all hospitalizations, within the last 10 years, except surgeries listed above. Give year of occurrence

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ALLERGIES: List allergies with the reaction you experience.

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MEDICATIONS: List name of any medication(s) you commonly take along with dose (how much you take) and frequency (how often you take it).

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HANDICAPS: So we may help provide for your needs, please list any physical handicaps which may require special

equipment or accommodations.

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I the undersigned student (if 18 years of age or older) or the parent or guardian of the above named student (if the student is 17 years of age or younger) do hereby affirm that the above information is accurate and complete. I, the undersigned, do hereby authorize, in the case of illness or injury, any diagnostic or therapeutic examination, procedure, or treatment deemed advisable by and rendered under the supervision of, the Student Health Physician or other health care providers selected by faculty, officers, or agents of Andrews University or selected by the undersigned. Consent is hereby granted to the Student Health Service to release pertinent medical information to the aforementioned health care providers, and to give any test and/or immunization required of University Students if such test or immunization has not been completed or documentation of completion is lacking. Such test or immunization may include but may not be limited to measles, mumps, and rubella, tetanus, tuberculosis skin test, hemoglobin, and urine for glucose and protein.

Student____ Dated

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Parent or Guardian____________________________________ Witness

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DEPARTMENT OF NURSING

MEDICAL EVALUATION

PART II

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:

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Ht________ Wt________ BP_______/_______ Vision: O.D. ________ /20 ____________ Corrected

O.S. ________ /20 ____________ Uncorrected

EXAMINATION

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

Are there any physical deformities or limitations? No ______ Yes _______.

(If yes, explain)

Are there any physical or emotional illnesses or conditions that may require ongoing medical care? No _______ Yes

(If yes, explain)

Care Provider's Signature ____ Date _______/ /_______.

Name (Print or Stamp) ____ Phone

Address