SAN JACINTO COLLEGE
BACHELOR OF SCIENCE IN NURSING

PHYSICAL EXAM FORM

PAGE 1 TO BE FILLED OUT BY THE APPLICANT/STUDENT:

Identifying Information:

Name: _____
Last **First** **Middle**

Home address: _____ **Phone:** _____

Medical History: Please place a checkmark below 'yes' or 'no'.

	No	Yes
1. Shortness of breath or moderate exertion	____	____
2. Hoarseness, excessive coughing	____	____
3. Tuberculosis	____	____
4. Seizure disorder	____	____
5. Mental disorders/ Epilepsy/ Emotional instability	____	____
6. Frequent headaches	____	____
7. Rheumatism or rheumatic fever	____	____
8. Diabetes	____	____
9. Heart disease	____	____
10. Hay fever/sinus infections	____	____
11. Asthma	____	____
12. Drug reactions	____	____
13. Musculo-skeletal problems	____	____

If you checked 'yes' on any of the above, please explain below: _____

_____

_____

14. Childhood diseases (i.e. measles), list if significant _____

15. Medical conditions, list if significant _____

16. Surgeries, list if significant _____

17. Injuries, list if significant _____

18. Allergies _____

19. Immunizations:
TB Skin Test Date: _____ Result: _____
Chest X-Ray (If TB Skin Test and/or BCG Vaccine) Date: _____
Flu Vaccine: Date: _____
TDAP Date: _____
MMR, Varicella, Hepatitis C, & Hepatitis B* Need positive titer series for these immunizations

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PHYSICAL EXAM FORM

Pages 2 to be completed by a Physician, Nurse Practitioner, or Physician Assistant.

Name: _____ Gender: _____ Weight: _____ Height _____

PHYSICAL EXAMINATION **PHYSICAL EXAM DATE: _____**

Check each item in appropriate column	Normal	If abnormal or with limitation, please detail or attach a sheet if necessary
Eyes		
Ears/Hearing		
Nose/Throat		
Mouth/Teeth		
Thyroid		
Vascular		
Lungs		
Heart		
Heart Rate:		
Blood Pressure:		
Neck & Vertebrae		
Extremities; Range of Motion		
Hand/Eye Coordination		
Fine Motor Dexterity		
Neurological/Reflexes		
Skin		
Abdomen		
Kidneys & Bladder		
Other		

RECOMMENDATIONS:

Yes: ____ No: ____ Based upon your physical examination and in your professional judgment, is the applicant capable of participating, without restrictions, in a nursing education program? If no, please describe:
_____

Yes: ____ No: ____ Does the applicant/student possess adequate visual and auditory acuity to practice as a health care professional? If no, please describe: _____

REMARKS: (General Statement of Physical Condition if needed)

Name of Office/Facility with Address and Phone Number: _____

Printed Name of MD/DO/Nurse Practitioner/Physician Assistant: _____

Signature of MD/DO/Nurse Practitioner/Physician Assistant: _____ Date: _____