

Name _____	Sex _____	Age _____	Date of Birth _____
Address _____		Phone _____	

Answer the following questions. Explain all "YES" answers at the bottom of the page.

1. Do you have an ongoing medical condition requiring care or medications? Yes No
2. Has a doctor ever restricted your work related activities? Yes No
3. Have you ever spent the night in the hospital? Yes No
4. Have you ever had surgery? Yes No
5. Do you have any heart or lung conditions? Yes No
6. Do you cough, wheeze, or have difficulty breathing? Yes No
7. Does your heart race or skip beats? Yes No
8. Have you ever passed out or nearly passed? Yes No
9. Have you ever had a seizure? Yes No
10. Do you have any jaundice (yellow skin), fever, chills, unexplained weight loss? Yes No
11. Have you ever been treated for latent tuberculosis or active tuberculosis disease? Yes No
12. Do you have anemia or have you ever been treated for anemia? Yes No
13. Do you suffer from anxiety or panic attacks? Yes No
14. Have you had any broken bones or dislocated joints? Yes No
15. Do you regularly use any brace? Yes No
16. Do you have problems walking? Yes No
17. Do you need an assistive device to walk? Yes No
18. Have you had back problems, back pain or back injury? Yes No
19. Have you had neck problems, neck pain or neck injury? Yes No
20. Have you had knee or leg problems, pain or injury? Yes No
21. Have you had foot problems, foot pain or foot injury? Yes No
22. Do you have numbness, tingling, burning or pins and needles of the arm, hands, feet or legs? Yes No
23. Have you ever had a hernia? Yes No
24. Do you have any rashes, pressure sores, or other skin problems? Yes No
25. Have you had any problems with your eyes or vision? Yes No
26. Do you wear glasses or contact lenses? Yes No
27. Do you have loss of vision? Yes No
28. Do you have hearing problems or hearing loss? Yes No
29. Do you wear a hearing aid? Yes No
30. Have you ever lost time from work for any health-related reason? Yes No
31. Have you ever been treated for nervous or mental disorder or addiction? Yes No
32. Do you have any concerns that you would like to discuss with a health care provider? Yes No

When was your last eye doctor appointment? _____

Do you smoke? Yes No If YES, how much per day _____ for how long? _____

Do you drink alcohol? Yes No If YES, what do you drink (circle all that apply)? BEER WINE LIQUOR

How many drinks at each sitting? _____

List all prescriptions medications, vitamins, herbal preparations and over the counter medications you take.

Explain all YES answers in the space below. Reference the item number in your explanation.

Abraham Baldwin Agricultural College School of Nursing and Health Sciences

Nursing Program History and Physical Form

Name _____ Age _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____/_____/_____ NOTE: All Areas of This Form Must Be Filled Out

PHYSICAL EXAMINATION BY MD, DO, NP or PA	NORMAL	ABNORMAL WITH FINDINGS
General Appearance		
Skin		
Head/Ears/Eyes/Nose/Throat		
Neck		
Thorax and Lungs		
Heart		
Spine and Back		
Abdomen		
Extremities/Peripheral Vascular		
Musculoskeletal		
Neurologic		

Printed Name of Practitioner _____ Practitioner Signature _____

Address _____ Phone _____ Date _____

AGILITY AND DEXTERITY TESTING BY RN, LPN OR MA (May deferred in pregnancy)	NORMAL	ABNORMAL WITH FINDINGS
5 Squats		
Lift Basket with 20 Pounds off Shelf, Place on Floor, Stand up, Retrieve Basket Off Floor and Place on Shelf		
Thread a Chain Overhead		

Printed Name of Practitioner _____ Practitioner Signature _____

Address _____ Phone _____ Date _____

HEARING SCREENING BY RN, LPN OR MA	500 Hz		1000 Hz		2000 Hz		3000 Hz		4000 Hz		6000 Hz	
(P)ASS/(F)AIL AT 50 Db OR LESS	R	L	R	L	R	L	R	L	R	L	R	L

Printed Name of Practitioner _____ Practitioner Signature _____

Address _____ Phone _____ Date _____

VISION TESTING BY RN, LPN OR MA (Test corrected vision, if applicable)
 Vision Test for Red-Green Deficiencies Using Pseudoisochromatic Plates (Ishihara Compatible) Pass Fail
 Near Vision Pass Fail Snellen Right Eye 20/____ Left Eye 20/____ Both Eyes 20/____
 Printed Name of Practitioner _____ Practitioner Signature _____

Address _____ Phone _____ Date _____

History and Physical Reviewed by ABAC School of Nursing and Health Sciences Faculty and Student Is:

Cleared without restriction Cleared, with recommendations for further follow up for: _____

Not Cleared _____

Signature _____ Date _____