NORTHERN ARIZONA UNIVERSITY

College of Nursing

Physical Examination Form

You are required to have a licensed health care provider perform a physical exam and discuss your medical history with you prior to entry into the nursing program.

Name _____ Date of Birth _____ ☐ Male ☐ Female

Exam Date: _____

1. Height: _____ Weight: _____ Posture: _____ BP: _____
2. Eyes: Vision R/20 _____ corrected by glasses to 20/ _____
   L/20 _____ corrected by glasses to 20/ _____
   Color Perception: _____ External exam _____
   Pupillary reaction: _____
3. Ears: Hearing (low conversational voice) R _____ L _____
   Inspection including tympanum: R _____ L _____
4. Nose and Throat: _____
5. Mouth and Teeth: _____ Caries _____ Missing Teeth: _____
6. Cardiovascular: Heart Sounds: _____ Pulse: _____
   Varicosities? _____
7. Abdomen: _____ Hernias: _____
8. Glandular System: Lymph: _____ Thyroid: _____ Mammary: _____
9. Bones, Joints & Muscles: _____
10. Nervous System, including tendon reflexes and gross coordination:
    _____
11. Skin: _____
12. Lab Urinalysis: Albumin _____ Sugar _____
    Micro (if indicated) _____
13. Limitations or Restrictions on physical activity, diet, etc? Why?

_____

_____

_____

Upon completion of the physical exam please fill out the Healthcare Provider Certificate and upload to Exxat. Please verify that the exam date is filled out.

Personal medical history on reverse page.

Provider to review and comment on all yes answers in space below.

Student/Patient Personal History - Please answer all questions

Name _____ **Date of birth** _____ **Exam Date:** _____

HAVE YOU HAD?	Yes	No	HAVE YOU HAD?	Yes	No
Eczema	☐	☐	Shortness of breath	☐	☐
Acne	☐	☐	Asthma	☐	☐
Head Injury with Unconsciousness	☐	☐	Chronic Cough	☐	☐
Dizziness or Fainting	☐	☐	Cystic Fibrosis	☐	☐
Eye Trouble	☐	☐	Chest Pain	☐	☐
Ear Problems	☐	☐	Palpitations (Heart)	☐	☐
Hearing Difficulty	☐	☐	Rheumatic Fever	☐	☐
Nose Problem	☐	☐	Heart Murmur	☐	☐
Sinusitis	☐	☐	High Blood Pressure	☐	☐
Hay fever	☐	☐	Low Blood Pressure	☐	☐
Gum or Tooth Trouble	☐	☐	Anemia	☐	☐
Throat Problem	☐	☐	Sickle Cell	☐	☐
Neck Injury	☐	☐	Bleeding Disorder	☐	☐
Do you smoke?	☐	☐	Stomach Trouble	☐	☐
Do you use marijuana?	☐	☐	Intestine Trouble	☐	☐
Bronchitis	☐	☐	Gall Bladder Trouble	☐	☐
Pneumonia	☐	☐	Jaundice	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
HIV Infection Exposure	☐	☐	Recurrent Diarrhea	☐	☐
Recurrent Constipation	☐	☐	Malaria	☐	☐
Recent Weight Gain	☐	☐	Chicken Pox	☐	☐
Hernia	☐	☐	Diabetes	☐	☐
Hemorrhoids	☐	☐	Thyroid Problem	☐	☐
Do you drink alcohol?	☐	☐	Tumor, Cancer, Cyst	☐	☐
Back Problems	☐	☐	Sexually Transmitted Disease	☐	☐
Disease/Injury of Joints	☐	☐	Herpes	☐	☐
Bladder Infection	☐	☐	**FEMALES ONLY:**	☐	☐
Kidney Infection	☐	☐	Irregular periods	☐	☐
Weakness, Paralysis	☐	☐	Severe Cramps	☐	☐
Seizures	☐	☐	Excessive Flow	☐	☐
Recurrent Headaches	☐	☐	Abnormal PAP	☐	☐
Insomnia	☐	☐	Pregnancy	☐	☐
Frequent Anxiety	☐	☐	Cystic Breasts	☐	☐
Frequent Depression	☐	☐	**MALES ONLY:**	☐	☐
Worry or Nervousness	☐	☐	Prostate Problems	☐	☐
Mononucleosis	☐	☐	Lump or Mass in Testicle	☐	☐

Comments _____