Bachelor of Science Nursing Medical Exam

Legal Name_____**Age** _____ **Sex** _____
(FIRST) (MIDDLE) (LAST)
Name you prefer to be called by: _____ **BYU-I#** _____
School address: _____ **Phone No.** _____
Home address: _____**Phone No.** _____
Birthday: _____ **Single** _____ **Married** _____ **Spouse Name:** _____
Family History: (Parents)
Father's Name: _____ **Age:** _____ **Living:** _____ **Deceased:** _____
If deceased, Cause of Death: _____ **Age at Death:** _____
Mother's Name: _____ **Age:** _____ **Living:** _____ **Deceased:** _____
If deceased, Cause of Death: _____ **Age at Death:** _____

IMMEDIATE FAMILY HEALTH PROBLEMS: (Have your parents or siblings ever had any of the following.)

Family History Of	Y	N	Family History Of	Y	N	Family History Of	Y	N
ADHD			DIABETES			MYASTHIANA GRAVIS		
ALLERGIES			DIGESTION PROBLEMS			RHEUMATOID ARTHRITIS		
ANEMIA			HEART TROUBLE			SEIZURE		
ANXIETY			HEMOPHILIA			SUICIDE (THOUGHTS/ACTS)		
BIPOLAR DISORDER			LIVER/KIDNEY/BLADDER PROBLEMS			ULCERS		
CANCER OR TUMOR			LOW/HIGH BLOOD PRESSURE					
DEPRESSION			MENTAL HEALTH ISSUES					

YOUR PERSONAL MEDICAL HISTORY: Do you now have or have you ever had?

YOUR HEALTH PROBLEMS	Y	N	YOUR HEALTH PROBLEMS	Y	N	YOUR HEALTH PROBLEMS	Y	N
ADHD			HEPATITIS			SUICIDE THOUGHTS		
ALLERGIES (FOOD/DRUG/OTHER)			HERNIA (TYPE)			THYROID PROBLEM		
ANXIETY			HIGH BLOOD PRESSURE			TUBERCULOSIS		
ASTHMA			HIVES OR RASHES			UNEXPLAINED WEIGHT LOSS		
BIPOLAR DISORDER			HIV VIRUS			URINARY TRACT INFECTION		
BROKEN/DISEASED BONES			HOSPITALIZATIONS (SPECIFY)			VENEREAL DISEASE		
CANCER OR TUMOR			INFECTIOUS MONO			WARTS		
CHRONIC FATIGUE SYNDROME			KIDNEY DISEASE/TRANSPLANT			OTHER HEALTH PROBLEMS: (LIST)		
CYSTS			LIVER DISEASE/TRANSPLANT					
DEPRESSION			LUPUS			FEMALES ONLY		
DIGESTION PROBLEMS			MIGRAINE HEADACHES			AGE WHEN STATED PERIODS		
DIABETES/HYPOGLYCEMIA			OBESITY			HEAVY BLEEDING WITH PERIODS		
DYSLEXIA			PNEUMONIA			BLEEDING BETWEEN PERIODS		
EAR INFECTIONS OR HEARING LOSS			POLIO			IRREGULAR PERIODS		
EATING DISORDER (ANOREXIA/BULEMIA)			RHEUMATIC FEVER			LUMPS IN BREASTS		
ECZEMA			SEIZURES			PREGNANCY		
HEART PROBLEM			STOMACH TROUBLE/ULCER			DATE OF LAST PAP SMEAR		

(If extra room is needed for any of the following, please continue on a separate paper)
Will you require any accommodating equipment to fulfill your nursing responsibilities? ____ If yes, list all._____
Are you currently on medication? _____ If yes, list all. _____
Are you allergic to any medication? _____ If yes, list all. _____
Do you have a known allergy to latex? _____ If yes, please provide documentation from a healthcare provider.

Student Signature _____

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REPORT OF HEALTH EVALUATION: (To be filled out by PHYSICIAN OR NURSE PRACTITIONER)

Student's Name: _____ Birth Date: _____

Height	Weight	B/P	Resp.	Pulse	Temp
Hearing (if indicated)		RIGHT		LEFT	
Vision	20/	20/	Corrected Vision	20/	20/

Are there any abnormalities in the following systems? If so, please describe fully.

SYSTEM	YES	NO	COMMENTS
Head, Ears, Nose or Throat			
Eyes			
Respiratory			
Cardiovascular			
Hernia			
Neuro/Psychiatric			
Skin			
Muscular			
Speech			
GI/GU			

Specify: Can student stand and/or walk for long periods of time? YES ☐ NO ☐

Can student complete a 12- hour nursing clinical without special accommodation? YES ☐ NO ☐

Specify accommodation if required._____

Student is: **Released without limitations** ☐

With limitations ☐

If limitations, what are they?_____

Physician's Signature: _____

Print Name: _____**Date:**_____

Address: _____