



Licensed Practical Nurse Program
Physical Examination form

Name _____ Date _____
Last First MI

Local Address _____

Birth date _____

Notify in case of emergency:

Name Address Phone Number

Personal History (to be completed by student):

Allergies (please specify):

Surgery (please list w/ date):

DRUGS _____ YES NO

FOOD _____ YES NO

OTHER _____ YES NO

Communicable Diseases (please specify):

Accidents (please list w/ date):

SCARLET FEVER _____ YES NO

VARICELLA _____ YES NO

MALARIA _____ YES NO

MONONUCLEOSIS _____ YES NO

HEALTH PROBLEMS:

- | | | |
|---------------------------------|------------------------------|-----------------------------|
| Eye Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ear, nose, throat trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Insomnia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent headache | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Head injury w/ unconsciousness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Tuberculosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chest pain/pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chronic cough | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| High blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Rheumatic fever/heart murmur | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Problem with muscles and joints | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Back problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Stomach or intestinal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gallbladder problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent diarrhea problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hernia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Paralysis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Psychiatric problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hepatitis A, B etc. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Other _____ | | |
| _____ | | |
| _____ | | |

Health Exam (To be completed by physician or certified nurse practitioner):

HEIGHT _____

BP _____

WEIGHT _____

PULSE _____

Review of systems (please check):

	Normal	Abnormal	Comments, if any:
1. Head, neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Immunization record (required):

Negative TB test or negative chest x-ray within the last year.

Date: _____ Result: _____

Hepatitis B

Date: _____

In your opinion, is patient able to care for a patient as required in LPN program?

YES NO

COMMENTS: _____

Summary of general health status: _____

Date: _____

Signature: _____

Examining Health Professional

Address: _____
