Southwest Minnesota State University
Department of Nursing
1501 State Street
Marshall, MN 56258

This information is confidential and will not be released to anyone without your knowledge and consent.

The cost of the physical is your responsibility. Please complete this page before going for your examination.

Last Name (please print) | First Name | Middle | Date of Birth | Sex (M or F)

Address (number & street) | City or Town | State | Zip Code

On the list below, check past if you have had these problems or symptoms but are not having them at present; check present if you are experiencing them now; check never if you have never had them.

	Present	Past	Never		Present	Past	Never		Present	Past	Never
Surgery (list)				Radiation Therapy				Urinary Frequency			
				Dental Problems				Sexually Transmitted Disease			
				Vision/Eye Problems				Cold Sores			
Blood Transfusions				Ear, Nose, Throat Problems				A.I.D.S.			
Allergies				Shortness of Breath				Hepatitis (kind)			
drugs (list)				Chronic Cough				Jaundice			
bee Sting				Emphysema				Hernia Rupture			
serum				Tuberculosis				Digestive Problems			
foods (list)				Pain/Pressure in Chest				Ulcers			
other (list)				Heart:				Bowel Problems			
Hayfever/Asthma				murmur				Recurrent Diarrhea			
Malaria				disease				Unexplained Rectal Bleeding			
Recurrent Colds				Blood Pressure:				Weight:			
Recurrent Headaches				high				recent loss			
Epilepsy Seizures				low				recent gain			
Severe Head Injury				Rheumatic Fever				Psoriasis			
Worry Nervousness				Thrombophlebitis				Skin Disease (list)			
Insomnia/Anxiety				Dizzy/Fainting				Chemical Dependency:			
Frequent Depression				Blackout Spells				alcohol			
Suicidal Feelings/Attempts				Disease or Injury of Joints				drugs			
Anorexia Bulimia				Back Problems				tobacco			
Tumor:				Muscle Weakness Paralysis				Females only:			
benign				Diabetes				irregular periods			
malignant				Kidney Problems				severe cramps			
Fibrocystic Breasts								excessive flow			

If any of the above questions were answered "present" please explain in the space below

Please answer the following questions

	Yes	No	If yes, please explain here:
1. Has your physical activity been restricted during the past five years? (Give reason and duration)			
2. Have you received treatment for any chemical dependency problem?			
3. Have you received treatment or counseling for a nervous condition, personality character disorder or emotional problem?			
4. Have you had any illness or injury or been hospitalized other then already noted?			
5. Have you consulted or been treated by physicians or other practitioners within the past five years other then routine checkups?			
6. Do you take any medications regularly? (If yes, list)			
7. Do you have a medical disability or handicap?			
8. Do you have any questions concerning your health, family history, or other matters which you would like to discuss with a member of the faculty?			

I certify that this information is true and complete to the best of my knowledge and agree that any misrepresentations or deliberate omissions of a material fact on this questionnaire may result in my not being permitted to enter the program, or may result in termination.

Student Signature _____ Date _____

MEDICAL EXAMINATION

To the Examining Physician: Please review this individual's health history and then complete this form. Please comment on all of the positive answers. This information will be used as a background for providing health care when necessary. Please be advised that the cost of your examination must be assumed by the individual.

Height _____ inches	Weight _____ lbs	Color Blind	_____ Yes	_____ No
Blood Pressure _____	____ Dressed ____ Undressed	Vision without Glasses	_____ Rt20	_____ Rt20
Pulse Rate _____/min	Underweight lbs _____	Vision with Glasses	_____ Rt20	_____ Rt20
Regular? ____ Yes ____ No	Overweight lbs _____	Contact Lens	_____ Rt20	_____ Rt20
		Hearing	Rt _____ ft	Lt _____ft

GUIDELINES FOR REQUIRED IMMUNIZATIONS

Tuberculin Test (Mantoux)

- Date and result of test prior to beginning clinical experience and every 12 months after that while enrolled. If the test is positive, you must have a negative chest X-Ray within the past three years prior to beginning your clinical experience.

Measles (Red Measles, Rubeola)

- Dates of **two** doses of measles or MMR vaccine **or**
- **Physician** diagnosis of disease **or**
- Report of immune titer proving immunity

Mumps

- Dates of **two** doses of mumps or MMR vaccine **or**
- **Physician** diagnosis of disease **or**
- Report of immune titer proving immunity

Rubella (German Measles) – *Note: History of disease is not accepted*

- Dates of **two** doses of rubella or MMR vaccine **or**
- Report of immune titer proving immunity

Tdap (diphtheria, tetanus, and acellular pertusis)

- The combined Tdap injection is required within the last ten years

Hepatitis B

- Dates of vaccination are a series of three doses. At minimum, this series must be started before beginning clinical experience **OR**
- Signed Hepatitis B Waiver **or**
- Report of positive antibody

Chicken Pox (Varicella)

- History of disease **OR**
- History of positive titer

1. The Tuberculin (Mantoux) test is required. Date _____ Positive ____ Negative ____
   If positive, a chest x-ray is required. Date _____ Positive ____ Negative ____
2. MMR (Measles, Mumps, Rubella) **Two** vaccination dates required 1) _____ 2) _____
   (Pregnant women should not receive Rubella vaccine. Women receiving Rubella vaccine should wait three months before getting pregnant)
3. Tdap (diphtheria, tetanus, and acellular pertusis). **Must say Adacel and be dated after 2005**. _____
4. Hepatitis B Series: Date of 1st dose: _____ Date of 2nd dose: _____ Date of 3rd dose:_____
5. Polio/Oral. Date _____
6. Chicken Pox. Date of Disease _____ Date of immunization for Disease _____
7. Influenza Vaccine is due once a year. Date of last vaccine_____

LABORATORY STUDIES: (at discretion of Physician) list any that are done.

_____

_____

_____

_____

_____

Are there any abnormalities/impaired functions/disease conditions of the following? If yes, please explain.

	Yes	No
1. Head		
2. Eyes		
3. Ears, Nose, Throat		
4. Respiratory		
5. Cardiovascular		
6. Gastrointestinal		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic Endocrine		
10 Neurological		

Are there any dermatological conditions present? Yes _____ No _____
If yes, please explain _____

_____

_____

_____

By history and physical examination, is this individual a carrier of any communicable disease? Yes _____ No _____
If yes, please explain _____

_____

_____

_____

Is this individual now under treatment for any physical, emotional or psychiatric conditions? Yes _____ No _____
If yes, please explain _____

_____

_____

_____

Physician's Signature _____

Address _____

Please Print Last Name _____ Date _____

For School Use Only: Reviewed _____