Annual Medical Examination

Florida A&M University
School of Nursing
103 Ware/Rhaney Building
Tallahassee, Florida 32307-3500

The below named applicant is a candidate for admission to the School of Nursing. Your cooperation in performing the Pre-entrance Medical Examination and completing this form will assist both the applicant and the School of Nursing.

Name of Applicant: _____
(Last Name) (First Name) (Middle Name)

Local Address: _____
(Number and Street)

_____
(City) (State) (Zip code + 4)

Permanent Address: _____
(Number and Street

_____
(City) (State) (Zip code + 4)

Phone: _____ **Email:** _____ **Date of Birth:** _____
(Month) (Day) (Year)

PERSONAL HISTORY

Do you have or have you had?

	Yes	No		Yes	No
1. Measles			25. Anemia		
2. German Measles			26. Abnormal bleeding		
3. Mumps			27. Varicose veins		
4. Chicken Pox			28. Menstrual problems		
5. Malaria			29. Phlebitis		
6. Hepatitis			30. Arthritis		
7. Pneumonia			31. Chronic ear infection		
8. Tuberculosis			32. Eye problems		
9. Asthma			33. Insomnia		
10. Hayfever			34. Emotional problems		
11. Hives			35. Other significant disease		
12. Type 2 Diabetes			.36. Major fracture		
13. Diabetes mellitus			37. Major dislocations		
14. High blood pressure			38. Trick knee		
15. Frequent headaches			39. Back injury		
16. Migraine			40. Been knocked out		
17. Convulsions			41. Other major injury		
18. Chronic cough			42. Tonsillectomy		
19. Chronic bronchitis			43. Appendectomy		
20. Shortness of breath			44. Hernia repair		
21. Heart disease			45. Other major surgery		
22. Indigestion			46. Drug allergy		
23. Constipation			47. Learning disability		
24. Urinary infection					
49. Do you have adjustment problems, family or social					
50. Are you on long term medication?					
51. Is your general health good?					
52. a. Do you smoke? /Smoked?					
b. Do you drink alcoholic beverages?					
c. Are you on birth control pills?					
d. Did you ever take birth control pills?					
53. 1st day of last menstrual period. Date:					

FAMILY HISTORY

54. Allergy			59. Heart disease		
55. Cancer			60. High blood pressure		
56. Convulsions			61. Obesity		
57. Diabetes mellitus			62. Tuberculosis		
58. Emotional illness			63. Other		

COMMENTS ON ALL YES ANSWERS

Signature of Applicant

_____

Date: _____

To be completed by the Examiner

Vital Signs

Height	
Weight	
Temperature	
Pulse	
Respirations	
Blood Press.	

Hearing

Weber	
Rinne	

Vision

Distant	R 20/	Corrected to 20/
	L 20/	Corrected to 20/
Near	R	Corrected to
	L	Corrected to
Color	Abnormal	Normal

Systems

N = normal A = Abnormal	**N**	**A**
Respiratory		
• Head and Neck		
• Nose		
• Mouth and Throat		
• Teeth		
• Lungs & chest		
• Breasts		
Sensory		
• Ears		
• Eyes		
• Skin		
Endocrine		
• Thyroid		
Musculoskeletal		
• Extremities		
• Spine		
Cardiovascular		
• Heart		
• Peripheral vascular		
Nervous/Neurologic		
Gastro-intestinal		
• Abdomen		
• Hernia		
Genito-urinary		
Psychiatric		
• Mental status		

COMMENT ON ALL ABNORMAL FINDINGS

IMMUNATIONS – Please provide proof of immunization/vaccination for items below. You may attach a copy of your original immunization record, or provide proof via blood titer, which validates immunity.

MMR x 2

Tetanus (within in 10 yrs)

Hepatitis B x 3

Varicella (Chicken Pox)

Poliomyelitis

TUBERCULOSIS SCREENING – <u>You must attach complete documentation of PPD/ Tuberculin Skin Test administration and subsequent reading (within the past year) OR Chest x-ray results.</u>

URINALYSIS AND CBC – <u>You must attach the print out of the results of all lab work.</u>

Overall Evaluation	Yes	No
Has sensitivities to medication		
Is on long term medication		
Requires follow-up medical care		
Has limitations of physical activities		

Comments

Examiner's Name _____ MD____ PA _____ ARNP ____ Other ____

Signature _____ Date _____

Address _____

_____

_____

***<u>YOU MUST ATTACH RESULTS</u>** OF ALL RELEVANT MEDICAL SCREENINGS AND LAB WORK !!*