**Health Record Form for Nursing Students**

**Student Information**

* **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Nursing Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Year of Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health History  
Please indicate if you have had any of the following conditions:**

| **Condition** | **Yes ☐** | **No ☐** | **Comments** |
| --- | --- | --- | --- |
| **Asthma** |  |  |  |
| **Diabetes** |  |  |  |
| **Heart Disease** |  |  |  |
| **Allergies** |  |  |  |
| **Hypertension** |  |  |  |
| **Seizures** |  |  |  |
| **Tuberculosis** |  |  |  |
| **Chronic Back Pain** |  |  |  |

**Immunization Record**

* **Hepatitis B Vaccine: ☐ Yes ☐ No**
* **MMR Vaccine: ☐ Yes ☐ No**
* **Tetanus Vaccine: ☐ Yes ☐ No**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**