



**Nazareth College Department of Nursing
Annual Health Assessment**

Name:	DOB	Date:
Street, City, State, Zip:		
Home phone: ()		Cell phone ()
Emergency Contact Info	Name:	Relationship:
Phone Number of Emergency Contact:	Cell:	Work or Home:

In the last year, have you had any of the following:

YES	NO	
		AIDS or HIV Infection
		Anemia
		Anorexia/Bulimia
		Anxiety/Panic
		Arthritis
		Asthma
		Autoimmune Disease
		Back Pain
		Bleeding Disorder
		Bronchitis
		Cancer
		Chest pain
		Chickenpox
		Chronic Cough
		Diabetes
		Depression
		Dizziness/Fainting
		Drug/Alcohol Problem
		Seizures
		Fractures
		GERD
		Gallbladder Disease
		Gingivitis
		Glaucoma
		Head Injury
		Heart Disease
		Heart murmur
		Hemorrhoids
		Hepatitis
		Hernia
		Hives
		Hypertension
		Insomnia
		Intestinal Disease
		Jaundice
		Kidney Disease
		Kidney Stones
		Latex Allergy
		Learning Disability
		Liver Disease

		Loss of Limb
		Measles
		Migraine Headaches
		Mitral Valve Prolapse
		Mononucleosis
		Mumps
		Palpitations
		Paralysis
		Peptic Ulcer Disease
		Physical Disability
		Pneumonia
		Unintended weight loss
		Recurrent Diarrhea
		Rheumatic Fever
		Shingles
		Sinusitis
		Skin problems
		Stroke
		Thyroid Disease
		Tuberculosis/ + PPD
		Urinary Tract infection
		Weakness
		Other:

Comment on all YES Answers:

List all medications taken regularly including herbs, supplements & over the counter medications. _____

Has your physical activity been restricted during the past five years? ____ Yes ____ No

If YES, explain (providing reasons and durations): _____

Are you currently under treatment for any medical or emotional condition? ____ Yes ____ No

If yes, explain _____

Do you have limitations on physical activity? ____ Yes ____ No If yes, explain _____

Are there any psychiatric or mental health reasons why you should not participate in patient care?

____ Yes ____ No If yes, explain _____

If you have had a +PPD, date of most recent CXR _____

Do you currently have or have had any of the following symptoms?

YES	NO	
		A prolonged fever
		Chills or Night Sweats
		Chest Pain
		A productive cough for over three weeks
		Unexplained weight loss
		Loss of appetite
		Undue fatigue
		Blood Tinged Sputum

Comment on all YES answers

I certify that the information contained on this form is true and correct. I am aware that if during the course of the academic year my health status should change in a way that would impact my ability to perform in clinical setting, I must notify the Department of Nursing. Your signature below authorizes the release of this information between the Department of Nursing and Nazareth College Student Health Services.

Signature _____

Date _____