

Nazareth College Student Health Services

Nursing Student Annual Health Review

Please PRINT

Name: _____ Date of Birth: _____

Cell Phone: _____

Please list all physical and/or mental health conditions: _____

1. Please list all allergies to medications, foods, latex, etc. _____

Reaction: Anaphylaxis? Yes ___ No ___ GI Symptoms? Yes ___ No ___ Hives? Yes ___ No ___

2. Please list all medications that you take regularly (including those for psychiatric conditions, ADHD, contraceptives and supplements): _____

3. Have you been hospitalized in the previous year? Yes ___ No ___ *If yes, please list date and reason:*

5. Do you have any condition that would interfere with your ability to participate in a clinical setting or that would be a risk to others? Yes ___ No ___ *If yes, please explain:* _____

6. Do you have limitations on physical activity? Yes ___ No ___ *If yes, please explain:*

7. Have you had chicken pox? Yes ___ No ___
If no, dates of varicella vaccine 1. _____ 2. _____

8. Are you experiencing any of the following?

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

I certify that my responses above are complete and true to the best of my knowledge.

Signature

Date

Office Use Only:

BP _____ P _____ Reviewed by: _____ Date: _____

Comments: _____