



California State University Channel Islands
Health Sciences Department
HEALTH APPRAISAL

(This side to be completed by applicant)

Date: _____

Last Name: _____ First Name: _____ Middle: _____

Student ID#: _____ DOB: _____ Phone: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical History

Abdominal Pain Yes No

Allergies Yes No

If yes, list: _____

Anemia Yes No

Anxiety Yes No

Asthma Yes No

Back Pain/Injury Yes No

Depression Yes No

Diabetes Yes No

Eating Disorder Yes No

Epilepsy/Seizure Yes No

Headaches/Migraines Yes No

Head Injury/Concussion Yes No

Hearing Problems Yes No

Heart Disease/Murmur Yes No

Other: _____

Hernia Yes No

Kidney Disease Yes No

High Blood Pressure Yes No

Liver Disease/Hepatitis Yes No

Surgery Yes No

Date & Type: _____

Thyroid Disease Yes No

Ulcers/Gastritis/GERD Yes No

Vision Problems Yes No

Smoke Yes No

Packs per week: _____

Alcohol Use Yes No

Drinks per week: _____ Drinks per month: _____

Drug Use Yes No

Type/Frequency: _____

Current medications / herbs / supplements: Yes No List: _____

Who is your primary care physician? _____

Have you ever been hospitalized? Yes No

If yes, give date and reason for hospitalization: _____

Have you ever failed a physical examination? Yes No

If yes, please explain reason(s): _____

**This information may be shared with the department requesting the Health Appraisal
and/or with the medical facility to which I may be assigned.**

The above information is true and correct to the best of my knowledge.

Signature

Date

Over Please!

PHYSICAL EXAMINATION
(This side to be completed by Physician/Examiner)

Name: _____ ID#: _____

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Resp: _____ LMP: _____

Vision Screening: Right: 20/ _____ Left: 20/ _____ Both: 20/ _____

With glasses: Right: 20/ _____ Left: 20/ _____ Both: 20/ _____

Hearing Screening: Right: _____ Left: _____

TB SCREENING

Two-Step PPD Skin Test is required for all Health Science students.

(Students with a history of a positive TB test must submit a radiology report of a chest x-ray taken within 6 months.)

TB Mantoux Test given date: _____ Results date: _____ Induration: _____

TB Mantoux Test given date: _____ Results date: _____ Induration: _____

Chest X-ray date: _____ Chest X-ray results: _____

(Copy of Reading Report required.)

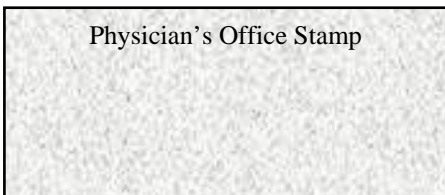
VACCINATIONS

(Students must have documentation of vaccinations or have titers demonstrating immunity.)

Vaccination	Date	Results	Vaccination	Date	Results
MMR #1		N/A	Hepatitis B #1		N/A
MMR #2		N/A	Hepatitis B #2		N/A
Rubella Titer*			Hepatitis B #3		N/A
Mumps Titer*			Hepatitis B Surface Antibody Titer*		
Rubeola Titer*					
Td/Tdap**		N/A	Varicella*		
**Must have been received within ten (10) years.			*Copy of blood tests results required		

EXAMINATION

Basic Exam		Yes	No	Comments
General:	Alert, well appearing, no apparent distress.	<input type="checkbox"/>	<input type="checkbox"/>	
Ears:	Canal without tenderness or exudate. TMs good landmarks/light reflex, no erythema.	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus:	Patent nares; no sinus tenderness to palpation.	<input type="checkbox"/>	<input type="checkbox"/>	
Pharynx:	No erythema, exudate; no tonsillar enlargement.	<input type="checkbox"/>	<input type="checkbox"/>	
Neck:	Supple, no adenopathy; no thyromegaly.	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs:	Equal breath sounds; no respiratory distress; no wheezes, rhonchi or rales.	<input type="checkbox"/>	<input type="checkbox"/>	
Heart:	Regular rhythm; no murmurs, gallops or rubs.	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen:	Active BS; soft; no tenderness, guarding, masses or organomegaly; no CVA tenderness.	<input type="checkbox"/>	<input type="checkbox"/>	
Skin:	No rashes, petechiae or other lesions.	<input type="checkbox"/>	<input type="checkbox"/>	
Neuro:	DTRs +2 bilaterally; strength 5+/5+; Romberg negative.	<input type="checkbox"/>	<input type="checkbox"/>	
Back:	Straight, full ROM; non-tender to palpation	<input type="checkbox"/>	<input type="checkbox"/>	
Other:				



Accepted for Program: Yes No

Physician/FNP Signature

Date