



# Channel Islands

CALIFORNIA STATE UNIVERSITY

## 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  
Over Please!

Date

## 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*			Varicella*		
Tdap**		N/A	<i>*Copy of blood tests results required</i>		
**Must have been received within five (5) years.			Proof of seasonal flu/H1N1 vaccination must be submitted annually by October 15		

### 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:				

Physician's Office Stamp

Accepted for Program: Yes  No

\_\_\_\_\_  
Physician/FNP Signature

\_\_\_\_\_  
Date