Channel Islands
CALIFORNIA STATE UNIVERSITY

Health Sciences Department
HEALTH APPRAISAL

Date: _____ *(This side to be completed by applicant)*

Last Name: _____ First Name: _____ Middle: _____

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

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

Medical History

Abdominal Pain	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
If yes, list: _____			High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Liver Disease/Hepatitis	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Surgery	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Date & Type: _____		
Back Pain/Injury	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Ulcers/Gastritis/GERD	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Smoke	☐ Yes	☐ No
Epilepsy/Seizure	☐ Yes	☐ No	Packs per week: _____		
Headaches/Migraines	☐ Yes	☐ No	Alcohol Use	☐ Yes	☐ No
Head Injury/Concussion	☐ Yes	☐ No	Drinks per week: ___Drinks per month:____		
Hearing Problems	☐ Yes	☐ No	Drug Use	☐ Yes	☐ No
Heart Disease/Murmur	☐ Yes	☐ No	Type/Frequency: _____		

Other: _____

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

A QuantiFERON Gold TB blood test is required annually for all Nursing students.
(Students with positive TB exposure must submit proof of a chest x-ray taken within 6 months, and renew every two years.)

QuantiFERON Gold TB Blood test result date: _____ Results: _____

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 every five years**		N/A	**Seasonal flu Date: (**vaccine must be submitted annually by October 1st)		
**Must have been received within five (5) years.			**Copy of blood tests results required*		

EXAMINATION

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

Physician's Office Stamp

Accepted for Program: Yes ☐ **No** ☐

_____ _____

Physician/FNP Signature Date