Houston Baptist University
School of Nursing and Allied Health
Medical Health Record

This form must be completed by a licensed health care provider (i.e., physician, nurse practitioner), preferably your family health care provider.

The medical examiner is requested to make a careful physical examination.

Date _____ Program: BSN

Name _____
Last First Middle

Address _____

Date of Birth _____ Gender: Male ¨ Female ¨

Family Health Care Provider _____

Address _____

Telephone # _____

In case of emergency please notify: Name _____

Address _____

Telephone # _____ Relationship _____

List of current medications (including vitamins, and complementary medicines or herbs):

_____

_____

_____

Personal Medical History: Check all that apply and describe below:

Alcohol/drug use ¨	Diabetes ¨	Hypertension ¨	Trauma/injury ¨
Allergies ¨	Hepatitis ¨	Psychiatric disorders ¨	_____
Anemia ¨	Hospitalizations ¨	Seizures ¨	_____ ¨

_____

_____

_____

Family Medical History: Check all that apply and describe below:

Anemia/blood disorders	¨	Heart disease < age 50	¨
Asthma/allergies	¨	Hypertension stroke	¨
Cancer	¨	Seizures	¨
Diabetes	¨	Tuberculosis	¨

_____

_____

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Name: _____

Physical examination:

Temp _____ BP _____ Pulse _____ Resp _____ HT _____ WT _____

Vision screen _____ Color vision screening _____

Please indicate below: N-Normal, A-Abnormal, NE-Not examined and explain any abnormalities, deformities, injuries,
limitations or significant findings:

N ¨ A ¨ NE ¨ Abdomen _____

N ¨ A ¨ NE ¨ Appearance _____

N ¨ A ¨ NE ¨ Chest/breasts _____

N ¨ A ¨ NE ¨ DTRS _____

N ¨ A ¨ NE ¨ Ears _____

N ¨ A ¨ NE ¨ Extremity _____

N ¨ A ¨ NE ¨ Eyes _____

N ¨ A ¨ NE ¨ Genitalia _____

N ¨ A ¨ NE ¨ Head _____

N ¨ A ¨ NE ¨ Heart/pulses _____

N ¨ A ¨ NE ¨ Lungs _____

N ¨ A ¨ NE ¨ Mouth/throat _____

N ¨ A ¨ NE ¨ Muscle tone _____

N ¨ A ¨ NE ¨ Neck _____

N ¨ A ¨ NE ¨ Nose _____

N ¨ A ¨ NE ¨ Skin/nails _____

N ¨ A ¨ NE ¨ Spine _____

N ¨ A ¨ NE ¨ Teeth _____

Explain abnormalities: _____

I HAVE EXAMINED _____ ON THIS DAY _____ AND FIND THE CLIENT TO BE IN GOOD PHYSICAL CONDITION and FIT FOR ACADEMIC and CLINICAL ACTIVITIES and with the physical, psychosocial, emotional, and critical thinking abilities to administer therapeutic interventions necessary in nursing care.

SIGNATURE _____ DATE _____

Laboratory Requirements: Each applicant must submit Measles, Mumps, Rubella (MMR), Varicella and Hepatitis B titer results that are not older than 5 years. MMR, Varicella, and Hepatitis B vaccines cannot be substituted for titers.

- Complete Blood Count (CBC)
- Measles, Mumps, Rubella (MMR) titers
- Varicella (Chicken Pox) titer
- Hepatitis B Surface Antibody
- Hepatitis C Antibody
- Urine Drug Screen

Date of Laboratory results: _____ All laboratory results must be attached to this completed health record.

Immunizations: Please attach copies of immunization records to this form.

	Series Original Dates	**Booster**
Polio		
DPT		TdaP required
MMR		
Hepatitis B		
Varicella		
Influenza		
TB Skin Test	Date:	Result

If TB skin test positive, submit:

Chest x-ray Date _____ Results _____

_____ _____

Health Care Provider Signature Date