MEDICAL HISTORY FORM
Prairie View A & M University College of Nursing
Houston, Texas

GENERAL INFORMATION (To be filled in by student) **DATE:** _____

Name in full _____
LAST NAME FIRST NAME MIDDLE NAME
Local Address _____

Home Address _____

Email: _____ Phone Number: _____

Date of Birth _____ Place of Birth _____
Month Date Year
Age _____ Gender _____ Marital Status _____ Citizenship _____

PERSONAL HISTORY (To be filled in by student)
Have you been addicted or treated for the abuse of alcohol or other substances within the past five (5) years? (You may answer no if you have completed and/or are in compliance with TPAPN for substance abuse). YES [ ] NO [ ] If yes, explain: _____
_____
_____

Have you, to the best of your knowledge, ever had any of the following: (yes or no). If yes please explain below this box.

Anemia_____	Hay Fever_____	Psychotic Disorders_____
Antisocial Personality Disorder_____	Hepatitis _____	Rheumatic Fever_____
Arthritis_____	Heart Disease _____	Schizophrenia_____
Asthma_____	Heart Defects_____	Seizures_____
Back Problem_____	Hernia_____	Sexually Transmitted Disease(s)_____
Bleeding Disorders_____	High Blood Pressure_____	Sickle Cell Anemia _____
Bipolar Disorder_____	Kidney Disease_____	Skin Disorders_____
Borderline Personality Disorder _____	Major Depression_____	Tonsillitis _____
Cancer_____	Migraines_____	Tuberculosis_____
Diabetes_____	Paranoid Personality Disorder_____	Ulcers _____
Gastrointestinal Disorder_____	Pneumonia_____	Other_____

Explanation for conditions noted in the above box:

Have you had any serious illness, operations or injuries? ____ If yes, explain: _____
_____
_____
_____

MEDICATION: Medications you are routinely taking including alternative medication and herbs: _____
_____
_____
_____

Allergies-medications, foods, **latex**, etc.: _____
_____

Date Form Completed by student _____ Date form reviewed by Healthcare Provider _____

Licensed Healthcare Provider (Printed) **(Signature)** M.D. D.O. P.A. N.P. (Circle correct title) Other

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ANNUAL PHYSICAL EXAMINATION FORM
Prairie View A & M University College of Nursing
6436 Fannin, Houston, Texas 77030

Name in Full _____
LAST NAME FIRST NAME MIDDLE NAME STUDENT ID #

PHYSICAL EXAMINATION (To be filled by Physician)

Height _____ Weight _____ Blood Pressure _____ Pulse _____
Please circle abnormal or normal as appropriate. If any area(s) is (are) abnormal please describe in Remarks below.

Eyes & Vision	Normal	Abnormal	Heart: Murmur	Normal	Abnormal
Ears & Hearing	Normal	Abnormal	Heart: Rhythm	Normal	Abnormal
Nose	Normal	Abnormal	Lungs	Normal	Abnormal
Throat (Adenoids and Tonsils)	Normal	Abnormal	Breasts	Normal	Abnormal
Gums	Normal	Abnormal	Abdomen	Normal	Abnormal
Tongue	Normal	Abnormal	Hernias	Yes	No
Teeth	Normal	Abnormal	Pelvis	Normal	Abnormal
Sinuses	Normal	Abnormal	Spine Posture	Normal	Abnormal
Skin	Normal	Abnormal	Upper Extremities	Normal	Abnormal
Thyroid	Normal	Abnormal	Lower Extremities	Normal	Abnormal
Heart: Size	Normal	Abnormal	Nutrition	Normal	Abnormal
Heart Sounds	Normal	Abnormal			

Explain any abnormal findings in the physical examination: _____

_____

_____

_____

_____

Explain previous medical history that may affect participation in clinical nursing activities: _____

_____

_____

_____

TB Skin Test or CXR Date given Date read Result Signature of provider

_____

Date

_____

Licensed Healthcare Provider (Printed) (Signature) M.D. D.O. P.A. N.P. (Circle correct title) Other

_____

Phone Number Address

_____

City State Zip Code

_____

Students are required to have a physical exam annually while enrolled in the nursing program. Should a student become pregnant or experience any change in health status during the annual year of the physical examination, the CON Laboratory Coordinator must be notified and an updated physical examination must be filed with the Lab Coordinator within two (2) weeks. Also, there must be a meeting with the academic advisor to review requirements of course enrollment.

PRAIRIE VIEW A & M UNIVERSITY COLLEGE OF NURSING
IMMUNIZATION RECORD

Name:_____ Address: _____ City/State/Zip: _____ Daytime Phone: _____ Emergency Name & Phone: _____ Health Insurance Company:	(Check which program you are entering) BSN _____ LVN to BSN _____ RN to BSN _____ MASTERS _____ Gender: Male _____ Female_____ Date of Birth: _____ Student ID# _____
Documentation of Immunizations (Provide Records and Test Results)	**Requirements**
DATE OF IMMUNIZATION FOR:	
TDAP Vaccine Required Date:	**TDAP Required;** CDC Recommendation for all Healthcare Providers
Required Measles: Seropositive titer confirmed: Date____ Mumps: Seropositive titer confirmed: Date____ Rubella: Seropositive titer confirmed: Date____	**MMR Titer Required**
Hepatitis B: Seropositive titer: _____ OR Date #1_____ Date #2_____ Date #3_____ **Hepatitis C Titer or Hep C Antibody Blood Test** Negative Status _____Yes _____No	**Hepatitis B: First two of series of three completed before enrollment and series completed as scheduled OR confirmation of seropositive titer.** **Hepatitis C Titer or Hepatitis Antibody Blood Test Required**
Required Varicella confirmation of Seropositive titer _____ ***History of disease is not acceptable*** Meningococcal Vaccine Date: _____ ***(Required for ages 29 and under)*** **SEASONAL FLU SHOT REQUIRED: Date: _____**	**Varicella Titer Required** **Meningococcal Vaccine Required** **Yearly Flu shot Required** **a. new incoming fall students submit evidence of immunization after Sept 1** **b. new incoming spring students also submit evidence of flu shot immunization after Sept 1**
TB Screening PPD (Mantoux, not Tine): Negative Positive Date: _____ _____ CXR Date: _____Negative: _____Positive: _____ If positive, please give details: _____ _____	TB Screening: Mantoux skin tests required (NOT Tine): Negative PPD within past year OR Negative CXR AND confirmation of prophylactic treatment. **TB Skin Test or Chest X-ray YEARLY**

DATE FORM COMPLETED: _____ Healthcare Provider's signature _____