



AMERICAN RIVER COLLEGE

Nurse Assistant Program

HEALTH HISTORY

The information on the health history form must be completed in its entirety and signed by the student. The health care provider must also review and sign this form at the time of student's physical examination.

Student: All sections must be completed - upper section, questions, & signature.

Name _____ LRCCD Student ID No. _____
 Health Care Provider Last First Middle
 Health Care Provider's Address _____
 City, State, Zip _____
 Health Care Provider's Telephone Number _____

YES NO The following questions are to be answered by checking either "Yes" or "No".

<input type="checkbox"/>	<input type="checkbox"/>	Have you been under a doctor's care in the last 12 months?		
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in the hospital in the last 12 months?		
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any type of surgery?		
<input type="checkbox"/>	<input type="checkbox"/>	Do you want to talk to a doctor about a health problem or any injury?		
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been restricted from any activity or employment because of a health problem or injury?		

Has anyone in your immediate family ever had:			YES	NO	Have you had or do you now have:
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (high sugar in blood)?	<input type="checkbox"/>	<input type="checkbox"/>	Hernia?
<input type="checkbox"/>	<input type="checkbox"/>	Allergies (hay fever or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems?
<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches? Heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	Loss of function or absence of testicles (Men) ?
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems (Women) ?
<input type="checkbox"/>	<input type="checkbox"/>	Has anyone in your family died suddenly?	<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture?
			<input type="checkbox"/>	<input type="checkbox"/>	Joint dislocation?
			<input type="checkbox"/>	<input type="checkbox"/>	Recurrent rash?
			<input type="checkbox"/>	<input type="checkbox"/>	Fungus?
			<input type="checkbox"/>	<input type="checkbox"/>	Foot problems?
			<input type="checkbox"/>	<input type="checkbox"/>	To wear a cast?
			<input type="checkbox"/>	<input type="checkbox"/>	Back injury or frequent backaches Knee injury (sprain) or recurrent pain?
			<input type="checkbox"/>	<input type="checkbox"/>	Ankle injury (sprain) or recurrent pain? Other joint problems, e.g., swelling pain, decreased range of motion?
			<input type="checkbox"/>	<input type="checkbox"/>	Bone infection?
			<input type="checkbox"/>	<input type="checkbox"/>	Weight problem (under or overweight)?
			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (high sugar in blood or urine)?
			<input type="checkbox"/>	<input type="checkbox"/>	Tendency to bleed or bruise easily?
			<input type="checkbox"/>	<input type="checkbox"/>	Anemia ("tired" blood)?
			<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble or murmur?
			<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure?
			<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough?
			<input type="checkbox"/>	<input type="checkbox"/>	Chest pain with exercise?
			<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or faintness with exercise?
			<input type="checkbox"/>	<input type="checkbox"/>	Asthma (wheezing)?
			<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever?
			<input type="checkbox"/>	<input type="checkbox"/>	Hives or rash?
			<input type="checkbox"/>	<input type="checkbox"/>	Bee sting reactions (allergy)?
			<input type="checkbox"/>	<input type="checkbox"/>	Reaction to medicine (allergy)?
			<input type="checkbox"/>	<input type="checkbox"/>	Athlete's foot?
			<input type="checkbox"/>	<input type="checkbox"/>	Recurrent boils (skin infection)?

Have you had or do you now have:		
<input type="checkbox"/>	<input type="checkbox"/>	Brain concussion (head injury)?
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to lose consciousness (faint)?
<input type="checkbox"/>	<input type="checkbox"/>	Skull fracture?
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or epilepsy?
<input type="checkbox"/>	<input type="checkbox"/>	Neck injury?
<input type="checkbox"/>	<input type="checkbox"/>	Impaired (poor) vision in one or both eyes?
<input type="checkbox"/>	<input type="checkbox"/>	Temporary loss of vision?
<input type="checkbox"/>	<input type="checkbox"/>	To wear glasses or contact lenses?
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss?
<input type="checkbox"/>	<input type="checkbox"/>	Perforated eardrum?
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from ear(s) (recurrent infections)?
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections?
<input type="checkbox"/>	<input type="checkbox"/>	Broken nose?
<input type="checkbox"/>	<input type="checkbox"/>	Dental Plate (dentures)?
<input type="checkbox"/>	<input type="checkbox"/>	Orthodontia (teeth straightened)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you.....
<input type="checkbox"/>	<input type="checkbox"/>	Smoke?
<input type="checkbox"/>	<input type="checkbox"/>	Take any medicine regularly? If "yes", name of medication _____ Take
<input type="checkbox"/>	<input type="checkbox"/>	medicine for emergency use? If "yes", name of medication _____

	If you answered "yes" to any question, please explain below:



**AMERICAN RIVER COLLEGE
PHYSICAL EXAM
NURSE ASSISTANT PROGRAM**

Upper Section to Be Completed by Student

Student ID Number _____

Last Name _____ First Name _____ MI _____
 Address _____ Phone _____
 City & State _____ Zip _____
 Birth Date _____ Age _____ Sex _____ Height _____ Weight _____

To Be Completed by Health Care Provider

Blood Pressure _____ Pulse Rate _____
 Significant Medical History _____
 Current Complaints of Disabilities Pertinent to Student's Participation _____

EXAMINATION (SYSTEM REVIEW)	NORMAL	ABNORMAL	COMMENTS
1. General Appearance			
2. Eyes & vision			
3. Ears, Nose & Throat			
4. Mouth & teeth			
5. Neck			
6. Lymph Nodes			
7. Respiratory			
8. Cardiovascular			
9. Abdomen			
10 Genitalia-Hernia			
11. Skin			
12. Neuro			
13. Musculoskeletal			

Recommendations Regarding Participation in the Nurse Assistant Program

- _____ 1. Can participate with no restrictions.
- _____ 2. No participation until: _____
- _____ 3. No participation

*The health care provider verifies that the individual does not have any health condition that would create a hazard for himself/herself, fellow employees, patients, and visitors.

NOTE: NO ACCOMMODATIONS ARE AVAILABLE FOR LIMITED, RESTRICTED, AND/OR PARTIAL PARTICIPATION.

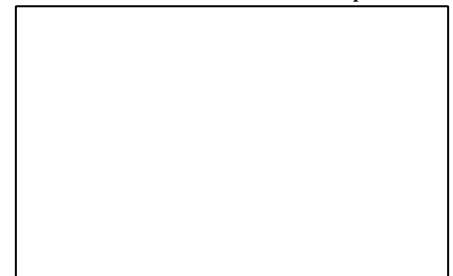
Health Care Provider's Name: Please review Health History completed by student (reverse) AND Physical Exam completed

 Health Care Provider's Signature Date

 Health Care Provider (Print) Telephone Number

 Address, City, State, Zip (Print)

**Verify Signature with
Health Care Provider's Stamp**



I hereby authorize release of pertinent medical records to American River College.	
_____ Student's Signature	_____ Date