BELL HEALTHCARE
TRAINING SCHOOL
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PHYSICAL EXAMINATION FORM FOR NURSING PROGRAM

Please complete all information to avoid return visits.

Part One: TO BE COMPLETED BY STUDENT PRIOR TO MEDICAL APPOINTMENT

Name: _____ Date of Exam: _____

Address: _____ Sex: [ ] Male [ ] Female

Cell: _____ Date of Birth: _____

HISTORY (Check Yes or No for each condition)

Allergies [ ] Yes [ ] No

Back Pain [ ] Yes [ ] No

Chest Pains [ ] Yes [ ] No

Chronic Cough [ ] Yes [ ] No

Diabetes [ ] Yes [ ] No

Epilepsy [ ] Yes [ ] No

Fainting or Dizziness [ ] Yes [ ] No

Headache (frequent) [ ] Yes [ ] No

Hearing Disability [ ] Yes [ ] No

Heart Trouble [ ] Yes [ ] No

Hepatitis [ ] Yes [ ] No

High Blood Pressure [ ] Yes [ ] No

Low Blood Pressure [ ] Yes [ ] No

Seizures [ ] Yes [ ] No

Shortness of Breath [ ] Yes [ ] No

Tuberculosis [ ] Yes [ ] No

Varicose Veins [ ] Yes [ ] No

Venereal Disease [ ] Yes [ ] No

Visual Disability [ ] Yes [ ] No

Other [ ] Yes [ ] No

Is the person free of communicable diseases? [ ] Yes [ ] No

If No, list precautions to prevent the spread of disease to others:

_____

Part Two: GENERAL PHYSICAL EXAMINATION (to be completed by physician)

Height: _____ Weight: _____ Blood Pressure: _____/_____

Pulse: _____ Respiration: _____ Temperature: _____

TUBERCULOSIS (TB) SCREENING:

TB Test Type: [ ] PPD Skin Test [ ] QuantiFERON Blood Test

Date Given: _____ Date Read: _____ Results: _____

If Positive, Chest X-ray (date): _____ Results: _____

Comments: _____

_____

_____

_____

_____

_____

_____ _____ _____

Name of Physician (please print) Physician's Signature Date

_____ _____

Physician Address: Physician Phone Number

Stamp