

COLLEGE OF SOUTHERN NEVADA

HEALTH HISTORY QUESTIONNAIRE

(Page 1 - completed by student. Page 2 completed by the healthcare provider.)

Patient Name _____ [?] Age _____ [?] Sex _____ [?]
(Last) (First) (Initial)

Address _____
(Street) (City) (State) (Zip Code)

Telephone # _____ **Date of Birth** _____ **NSHE ID #** _____

In Case of Emergency, Notify:

1. _____ <small>Name</small> _____ <small>Relationship</small> _____ <small>Home and/or Cell Phone</small>	2. _____ <small>Name</small> _____ <small>Relationship</small> _____ <small>Home and/or Cell Phone</small>
--	--

Physician

Telephone

Hospital

Do you have, or have you ever had, the following:

Yes	No	Unsure		Yes	No	Unsure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Liver/Intestinal trouble [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder/Gall Stone trouble [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent/Severe headaches [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or Hepatitis [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to serum/drugs/medicine/latex [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Trouble/Corrective lenses [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Color blindness [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat trouble [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rupture or hernia [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss or hearing aid [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol abuse [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones or blood in urine [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Sinusitis/Colds [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animal allergy [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VD/Syphilis/Gonorrhea [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin disease [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism/Bursitis [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughed up blood [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brace or back support [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Trick" or locked knee [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any disease of glands [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or excessive worry [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory or amnesia [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or mental disorder [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure [?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox [?]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuritis [?]				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (include infantile) [?]				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures [?]				

In an emergency, I authorize the CSN personnel in charge to use their discretion regarding the College's emergency procedures.

Explain "YES" answers as necessary: _____

Signed: _____

*Student or Parent Legal Guardian**

Current Medications: _____

Date: _____ **Students under age of 18*

PHYSICAL EXAMINATION

(Page 1 - completed by student. Page 2 - completed by the healthcare provider.)

Patient Name: _____ DOB: _____ Date: ____/____/____

Constitutional		<input type="checkbox"/> NAD	<input type="checkbox"/> W/DWN	Allergies	
Temp	BP	HR	RR	Height	Weight
HEAD		<input type="checkbox"/> NC/AT	<input type="checkbox"/> NL	<input type="checkbox"/> ABN	Gross Hearing
Eyes	<input type="checkbox"/> Ears, nose appear	<input type="checkbox"/> NL	<input type="checkbox"/> PERL	<u>COMMENTS</u>	
Ears	<input type="checkbox"/> Trachea	central	<input type="checkbox"/> Anicteric	<input type="checkbox"/> sclera	<input type="checkbox"/> Oropharynx
Nose	<input type="checkbox"/> Neck	supple, no masses	<input type="checkbox"/> NL	<input type="checkbox"/> conjunctiva	<input type="checkbox"/> N
Throat	<input type="checkbox"/> Y	supraclavicular, cervical	<input type="checkbox"/> nodes		
CARDIOVASCULAR					<u>COMMENTS</u>
Rate:		<input type="checkbox"/> Reg	<input type="checkbox"/> Tachy	<input type="checkbox"/> Brady	
Rhythm:		<input type="checkbox"/> Reg	<input type="checkbox"/> Irreg		
PMI:		<input type="checkbox"/> NL			
JVD:		<input type="checkbox"/> N	<input type="checkbox"/> Y		
Murmur:		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> systolic	<input type="checkbox"/> diastolic
LUNGS		Auscultation	<input type="checkbox"/> Clear	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Rales
Breath sounds		<input type="checkbox"/> NL	<input type="checkbox"/> Decr	<input type="checkbox"/> L	<input type="checkbox"/> R
		<input type="checkbox"/> Bases	<input type="checkbox"/> Apical		
		<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> Bilateral	
ABDOMINAL		<input type="checkbox"/> Soft, non-tender, w/o rebound, guarding, HSM, BS	<u>COMMENTS</u>		
		<input type="checkbox"/> Surgical scar			
		<input type="checkbox"/> other			
EXTREMITIES		<input type="checkbox"/> No cyanosis, clubbing, ischemia	<u>COMMENTS</u>		
Edema		<input type="checkbox"/> None	<input type="checkbox"/> Tr	<input type="checkbox"/> 1	<input type="checkbox"/> 2
		<input type="checkbox"/> 3	<input type="checkbox"/> 4		
SKIN		<input type="checkbox"/> Redness	<input type="checkbox"/> Vesicles	<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> Latex allergy
					<u>COMMENTS</u>
NEUROLOGICAL					<u>COMMENTS</u>
<input type="checkbox"/> No focal deficits		<input type="checkbox"/> Appropriate affect and intact judgment			
<input type="checkbox"/> Cranial nerves grossly intact		<input type="checkbox"/> Gait normal			
<input type="checkbox"/> Motor strength WNL		<input type="checkbox"/> Reflexes symmetrical			
<input type="checkbox"/> Sensory exams WNL		Romberg <input type="checkbox"/> - <input type="checkbox"/> +			

Does this individual require any special accommodations?

Yes No If yes, please explain.

Are there any limitations to the patient's full participation in school or work?

Yes No If yes, please explain:

Please Return To:

Healthcare Provider:

Print Name: _____

Signature: _____

Date: _____