VALLEY CAREER & TECHNICAL CENTER
WHERE PREPARATION MEETS OPPORTUNITY

49 Hornet Rd – Fishersville VA 22939
PH 540-245-5002 FAX 540-885-0407
Deadra Boyd, RN, BSN
Program Director

Physical Examination for School of Practical Nursing

(PLEASE PRINT)

Applicant's Last Name: _____ First Name: _____

Address _____

City_____ State_____ Zip_____

DOB (Month/Day/Year)_____ Social Security # - _____- _____- _____

Phone # _____

1. **Past Medical History.** ***(To be completed by Nursing Program Applicant)***
   Do you have any of the following health conditions?

Condition	Yes	No	Condition	Yes	No
Hearing Problem			**Depression**		
High Blood Pressure			**Worry/ Nervousness**		
Heart Problems			**Allergy/Hay fever**		
Diabetes (Type I or II)			**Respiratory Disorder**		
Thyroid Disorder			**Skin Disorder**		
Anemia			**Drug/Alcohol Problems**		
Seizure Disorder			**Sexual Diseases**		
Headaches			**Intestine or Stomach Problem**		
Dizziness/Fainting			**Mood or Thought Disorder**		
Do you have a disability?			**Have you ever had a serious illness?**		
Have you ever been hospitalized for physical or mental illness or an injury?			**Have you ever had a broken bone?**		
Have you ever had surgery?			**Have you ever had any serious injuries?**		

2. **Please explain any "Yes" answers for the above question.**

_____

_____

_____

_____

3. **Do you have health insurance? □ Yes □ No**

Name of Insurer: _____

PHYSICAL EXAMINATION

To be completed by healthcare provider

Applicant Name: _____ Date of Birth: _____/_____/_____

Ht: _____ Wt: _____ Temp: _____ Pulse: _____ RR: _____ B/P _____/_____

Allergies or Adverse Reactions: _____

Vision without correction: OD _____ OS _____ Both _____ With Correction: OD: _____ OS _____ Both _____

Physical Assessment:

System	Normal	Abnormal	Not Examined	Comments
Head, Eyes, Ears, Nose, Sinuses				
Mouth, Throat, Neck, Thyroid				
Nervous System, Reflexes				
Skin				
Chest and Lungs-Respiratory System				
Heart and Circulatory System				
Endocrine, Lymphatic				
Abdomen, GI system, Hernia				
Spine and Musculoskeletal System				
Genitourinary System				

List of applicant's current medications:

_____

_____

List any physical, emotional, or mental health conditions the applicant is currently being monitored for:

_____

_____

Provider Comments: _____

Provider's Name (printed): _____

Signature: _____ Date: _____

Provider's office address: _____

Phone Number: _____