Healthcare School of Hawaii
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Physical Examination Form

Name: _____ Sex: M _____ F _____ Marital Status: _____

Address: _____

Date of Birth: _____/_____/_____ Age: _____ Phone: Home _____ Cell _____

Emergency Contact: Name _____ Relationship _____

Phone _____

To be completed by student:

1. Have you been exposed to any communicable diseases such as: Chicken Pox, Shingles, Measles, Pertussis (Whooping Cough), Tuberculosis, Hepatitis A, B, C? a. If "Yes", Please Describe/Date _____	Yes _____ No _____
2. Do you have a history of back pains, back surgery, or leg pains that would prohibit you from lifting, turning, or performing the job description of a nursing assistant?	Yes _____ No _____
3. Are you pregnant? a. If "Yes", LMP _____ EDC _____	Yes _____ No _____
4. Any history of substance abuse, alcoholism or violent behavior?	Yes _____ No _____
5. Any history of depression or mental illness?	Yes _____ No _____

To be completed by Examiner (MD, PA, NP)

1. List of medications currently taking, dosage, and reason:

   _____

   _____

2. Restrictions/pains/disabilities:

   _____

   _____

3. Previous surgeries and dates:

   _____

4. Examiner's Summary:

   _____

   _____

Immunizations – Communicable /Infectious Disease History:

Tuberculosis - Date of last Skin Test: _____/_____/_____ Results: _____
Date of last CXR (if applicable): _____/_____/_____ Results: _____

After examining the above patient, I hereby declare that he/she has no restrictions to perform the duties of a nursing assistant.

Name of Examining MD/PA/NP: _____ Date: _____

Signature: _____ Clinic/Office Address: _____

_____

copy of this Physical Exam must be released to Healthcare School of Hawaii