

**Master of Science in Nursing  
Regents Online Degree Program  
Health History and Physical Examination Form**

**NOTE: HOME SCHOOL REQUIRED FORMS MAY BE SUBSTITUTED**

**HEALTH HISTORY - To be completed by student and/or health care provider**

Name: \_\_\_\_\_  Male  Female Birth Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

In Emergency, Notify \_\_\_\_\_ Phone # \_\_\_\_\_

**PLEASE CHECK (  ) ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST**

**OR HAVE AT PRESENT:**

Allergy  
Specify \_\_\_\_\_

Frequent Colds

Hay fever

Liver Disease

Anemia

Depression

Frequent Headache

Nervousness

Arthritis

Diabetes

Heart disease

Psychiatric Treatment

Artificial Joint

Drug/Alcohol  
Addiction

Hearing Trouble

Respiratory Trouble

Asthma

Epilepsy/Seizures

Hemophilia

Stroke

Bone or Muscle Trouble

Eye Trouble

Hepatitis

Tuberculosis

Cancer

Fainting or Dizzy  
Spells

Kidney Trouble

Ulcers

Comment on all positive responses and any other major illness, operations, injuries or other health problems:

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Have you ever been hospitalized?  yes  no If YES, for what, where and at what age?

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Do you currently take any medication on a regular or long-term basis?  yes  no

If YES, please specify \_\_\_\_\_

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Do you have any physical or mental health condition that would cause you or any other person to be placed in danger if you are admitted to and/or allowed to participate in the nursing program?  yes  no

If YES, please specify \_\_\_\_\_

Females Only: Are you currently pregnant?  yes  no If yes, what is your expected date of delivery? \_\_\_\_\_

Previous pregnancies/childbirths: \_\_\_\_\_ Complications \_\_\_\_\_

Pregnancy is not grounds for denial of admission or participation, but the health of the student must be adequate to meet class and clinical requirements.

**Immunizations and Tests - To be completed by physician or certified nurse practitioner**

**Immunization Requirements**

1. MMR/Rubeola - If born on or after January 1, 1957, provide written documentation of two (2) live measles (rubeola) vaccines given in no less that one month apart, after the first birthday; or written documentation of a measles/mumps/rubella vaccine since 1989, or written documentation of laboratory evidence of immunity to rubella and rubeola.

MMR/Rubeola Vaccine \_\_\_\_ date \_\_\_\_\_

Laboratory evidence of measles immunity (rubella and rubeola) attached

2. Varicella (Chicken Pox) - Provide written documentation of two (2) varicella vaccines given no less than one month apart or written documentation of immunity.

Varicella Vaccines \_\_\_\_ dates: \_\_\_\_\_ and \_\_\_\_\_

Laboratory evidence of chicken pox immunity (varicella titer IgG) attached

3. Hepatitis B - Provide written documentation of beginning a series of Hepatitis B vaccinations or provide written documentation of positive surface antibodies to Hepatitis B. (Series of three vaccinations must be completed as prescribed in order to continue in the program.)

Hepatitis B Vaccines #1 \_\_\_\_ date \_\_\_\_\_

#2 \_\_\_\_ date \_\_\_\_\_

#3 \_\_\_\_ date \_\_\_\_\_

Laboratory evidence of positive surface antibodies to Hepatitis B attached

4. Tetanus - It is recommended that the student receive a tetanus/diphtheria booster if ten (10) years have lapsed since last booster.

Date of last Tetanus booster \_\_\_\_\_  documentation attached

**Tuberculin Tests:** Provide written evidence of a negative TB skin test within the past three (3) months, or if there is a history of a positive TB skin test then provide a chest x-ray, demonstrating no evidence of active TB, dated within the past year.

Date of last TB skin test: \_\_\_\_\_ Results:  negative  positive \_\_\_\_mm

documentation attached

If TB skin test results are positive, date and result of last chest x-ray: \_\_\_\_\_

documentation attached

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*This is to verify that: \_\_\_\_\_ has had all immunizations that are necessary at this time or laboratory tests document immunity to communicable diseases.*

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*Date*

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*Signature of MD or NP*