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. _____ **2.** _____

Name *Name*

_____ _____
Relationship *Relationship*

_____ _____
Home and/or Cell Phone *Home and/or Cell Phone*

_____
Physician

_____
Telephon

_____
e Hospital

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

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

HEAD ❒ NC/AT ❒ NL ❒ ABN Gross Hearing COMMENTS

Eyes ❒ Ears, nose appear NL ❒ PERL

Ears ❒ Trachea central ❒ Anicteric sclera ❒ Oropharynx clear

Nose ❒ Neck supple, no masses ❒ NL conjunctiva ❒ N ❒ Y Supraclavicular, cervical nodes

Throat

CARDIOVASCULAR COMMENTS

Rate: ❒ Reg ❒ Tachy ❒ Brady

Rhythm: ❒ Reg ❒ Irreg

PMI: ❒ NL

JVD: ❒ N ❒ Y

Murmur: ❒ N ❒ Y ❒systolic ❒diastolic

LUNGS Auscultation ❒Clear ❒Wheezing ❒Rales ❒Rhonchi COMMENTS

Breath Sounds ❒NL ❒Decr ❒L ❒R ❒B

❒Bases ❒Apical

❒ L ❒ R ❒ Bilateral

ABDOMINAL ❒ Soft, non-tender, w/o rebound, guarding, HSM, +BS COMMENTS

❒ Surgical scar

❒ other _____

EXTREMITIES ❒ No cyanosis, clubbing, ischemia COMMENTS

Edema ❒ None ❒Tr ❒1 ❒2 ❒3 ❒4

SKIN ❒ Redness ❒ Vesicles ❒ Hyperpigmentation ❒ Latex allergy COMMENTS

NEUROLOGICAL COMMENTS

❒ No focal deficits ❒ Appropriate affect and intact judgment

❒ Cranial nerves grossly intact ❒ Gait normal

❒ Motor strength WNL ❒ Reflexes symmetrical

❒ Sensory exams WNL Romberg ❒ - ❒+

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: _____