

**SUNY Institute of Technology
Department of Nursing and Health Professions
100 Seymour Road, Utica, New York 13502**

SELF HEALTH ASSESSMENT

Throughout the duration of your clinical course work, The Department of Nursing and Health Professions requires a Physical Exam completed by a physician, PA or NP initially, and then every other year.

Opposite years, a Self Health Assessment completed by you is required.

Instructions: Please complete by checking the appropriate "Yes" or "No" column after each statement. A "Yes" response requires a brief explanation on page 2. Be sure to sign and date this form.

Please give this completed form to your clinical instructor for review and signature.

PLEASE PRINT

NAME: _____

U#: _____

SINCE YOUR LAST PHYSICAL EXAM HAVE YOU HAD OR DO YOU HAVE:

YES

NO

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|
| 1. Fainting, dizziness, epilepsy, convulsions, migraines? | _____ | _____ |
| 2. Heart disease, blood pressure problems, chest pains, shortness of breath? | _____ | _____ |
| 3. Asthma, emphysema, tuberculosis, bronchitis, pleurisy, pneumonia, coughing up blood, or other lung conditions? | _____ | _____ |
| 4. Ulcer, hepatitis, cirrhosis, colitis, gall bladder trouble, dysentery, chronic diarrhea, typhoid fever, salmonella infection, vomiting blood, rectal bleeding, or other disease of the stomach, intestines, or the rectum? | _____ | _____ |
| 5. Hernia (rupture), hemorrhoids (piles, pilonidal cyst, or varicose veins)? | _____ | _____ |
| 6. Bladder/kidney infections, stones, or venereal disease? | _____ | _____ |
| 7. Women: Pelvic infections or operations? Disabling periods to do excessive bleeding or cramping? Pregnancy? | _____ | _____ |
| 8. Men: Vericocele, hydrocele, prostate trouble, or disease of the testicle? | _____ | _____ |
| 9. Vision or hearing problems, sinus infections, or repeated headaches? | _____ | _____ |
| 10. Skin disease such as allergies, infections, etc.? | _____ | _____ |
| 11. Fractures, dislocated bones, arthritis, bursitis, gout, or joint problems? | _____ | _____ |
| 12. Neck or back problems such as whiplash, slipped disc, sciatica, or repeated backache? | _____ | _____ |
| 13. Operations? Medical or surgical treatment in hospital or mental institution? | _____ | _____ |
| 14. Accidents or injuries at work or away from work? | _____ | _____ |
| 15. Gain/loss of ten (10) pounds or more within the past year? | _____ | _____ |
| 16. Diseases not previously covered such as diabetes, thyroid, anemia, cancer, Rheumatic fever, etc.? | _____ | _____ |

SELF HEALTH ASSESSMENT - CONTINUED

- | | <u>YES</u> | <u>NO</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 17. Are you allergic to any drugs, medicines, or substances with which you might come into contact at work? | _____ | _____ |
| 18. Do you have any problem with habituation or addiction to alcohol or drugs? | _____ | _____ |
| 19. Have you ever been rejected for health reasons when applying for life or health insurance or has any insurance policy been cancelled for medical reasons? | _____ | _____ |
| 20. Have you ever been denied entrance into military service for health reasons or received a medical discharge? | _____ | _____ |
| 21. Have you ever been discharged from employment for health reasons? | _____ | _____ |
| 22. Are you now limited or have you at any time in the past year been restricted as to either the type or amount of work that you are permitted to perform? | _____ | _____ |
| 23. Are you presently under the care of a doctor?
(If your response is "Yes", please indicate below the diagnosis and treatment of the condition, if possible, including diet and medications: | _____ | _____ |

Your physician (name, address, phone number) _____

"Yes" response(s): Indicated question number, then your explanations; use additional sheet if necessary:

STUDENT SIGNATURE: _____ DATE: _____

REVIEWED BY: _____ DATE: _____