



# Southern Union

State Community College - Health Sciences

## Annual Health Questionnaire

<b>Student Name (Last, First, M)</b>		<b>Telephone</b> (     ) -		<b>SUSCC Student Number</b>	
<b>Program (Circle one)</b>	<b>Registered Nursing (RN)</b>	<b>EMT</b>		<b>Paramedic</b>	
	<b>Practical Nursing (PN)</b>	<b>AEMT</b>		<b>MRI/CT</b>	
<b>Allergies (Food/Drug/Latex, etc)</b>					
Height _____ Weight _____ BP _____/_____ Pulse _____					
Vision Right 20/_____ Left 20/_____ Corrected: Y N Color Blind: Y N					
<b>COMPLETE</b>	<b>LIMITED</b>	<b>NORMAL</b>		<b>ABNORMAL FINDINGS</b>	
		Cardiovascular			
		Pulses			
		Heart			
		Lungs			
		Skin			
		E.N.T.			
		Gastrointestinal			
		Musculoskeletal			
		Neurological			
		Other			

1. Has student been diagnosed with any chronic/serious medical condition(s)? (Ex. diabetes, hypertension, seizure disorders, etc.?) **Yes**  **No**  **If yes, please list:** \_\_\_\_\_
2. Has student been diagnosed with any psychiatric/mental condition(s)? (Ex. bipolar, depression, chemical dependency, etc.) **Yes**  **No**  **If yes, please list:** \_\_\_\_\_
3. Are the above conditions being presently controlled or treated? **Yes**  **No**  **If yes, please describe:** \_\_\_\_\_
4. Is student taking any prescribed medications on a regular basis? If so, please list: - \_\_\_\_\_
5. **On the basis of the examination on this day, I approve this student's participation in Health Sciences Clinical.** **Yes**  **No**  **Limited**  **If limited, comment is required.** \_\_\_\_\_

<b>Physician/Nurse Practitioner/Physician's Assistant PRINTED Name, Address, and Phone Number</b>		
Name	Address	Phone #
Physician/Nurse Practitioner/Physician's Assistant's Signature		Date
For the purpose of determining eligibility for my educational experiences, I hereby give my permission for the Division of Health Sciences to contact the Healthcare Provider who completed this health form for further information if needed. I understand that this form may be duplicated for a clinical agency upon request. NOTE: Additional medical examinations and a specific release from a physician may be required any time (for example, during pregnancy, infectious disease, interference with mobility, emotional instability, etc.) if it is deemed necessary for the faculty to evaluate your state of health.		
Student's Signature	Date	