Name _____

HN. HEALTH RECORD UPDATE-NURSING

COMPLETE ONLY IF CHANGES IN HEALTH STATUS OR DEMOGRAPHICS

Health Services
Health Record

1025 North Broadway, K250
Milwaukee, Wisconsin 53202
414-277-7590
Fax: 414-277-2897
www.msoe.edu/st_life/health/

(Check all that apply)

☐ Nursing Faculty in Clinicals

☐ Nursing Student in Clinicals ☐ **SOPHOMORE** ☐ **JUNIOR** ☐ **SENIOR**

(Transfer students must complete initial Health Record and physical exam as first-year student.)

Name _____ _____ _____
Last Name *First Name* *Middle*

Date of Birth ____/____/____ Gender: ☐ MALE ☐ FEMALE Expected Graduation Year _____
MM DD YY

Residence Hall _____ _____ Cell or Campus Phone _____
Residence Hall *Room Number*

Off Campus Address _____ Home Phone _____
(for commuter students) *Street City State Zip*

Permanent Home Address: _____ Business Phone _____
(if different from above) *Street City State Zip*

Emergency Contact _____ Home Phone _____
Name Relationship

Medical Insurance _____
Company Policy Number Group Number Phone # (Member Services)

TETANUS-DIPHTHERIA-PERTUSSIS (Must have booster with Td or Tdap in the last ten years) ____/____/____
MM DD YY

HEALTH HISTORY UPDATE TO BE COMPLETED AND SIGNED BY NURSING STUDENTS/FACULTY ONLY IF THERE ARE CHANGES IN HEALTH STATUS

	Circle One	Comments			
Dx Arthritis/Limitations	Yes No		Immune suppressed?	Yes No	
Diagnosis of Asthma? Wheeze/Cough During or After Play?	Yes No	Indicate Severity:	Loss of Function of One of Paired Organs? (Eye/Ear/Kidney/Testicle)	Yes No	
Back Problems?	Yes No		Hospitalizations? When? What for?	Yes No	
Birth Defects?	Yes No		Surgery? (List All) When? What for?	Yes No	
Developmental Delay?	Yes No		Serious Injury or Illness?	Yes No	
Blood Disorders? Hemophilia, Sickle Cell, Other? Explain	Yes No		Tobacco Use (Type, Frequency)?	Yes No	
Diabetes?	Yes No		Alcohol/Drug Use?	Yes No	
Head Injury/Concussion/Passed Out?	Yes No				
Seizures? What are they like?	Yes No		Family History of Sudden Death Before Age 50? (Cause?)	Yes No	
Rapid, Irregular Pulse/Shortness of Breath?	Yes No		**Current Medications**		
Heart Murmur/High Blood Pressure/Passing out?	Yes No		(Circle) Dental Bridge Plate Braces Other Molars-remain/removed		
Dizziness or Chest Pain with Exercise?	Yes No		(Circle) Eye/Vision Problems? Glasses Contacts Last Exam Date _____ Other Concerns?		
Bone/Joint Problems/Injury? Scoliosis?	Yes No		Are you presently under care for a medical or emotional condition? **Changes in Health Status:**		
Ear/Hearing Problems?	Yes No		Student (Parent or Guardian if Student is under 18 years of age)		
Allergies:	Yes No	List:			
Athletes: Have you ever been denied participation in sports due to health reasons?	Yes No		X_____ Signature Required Date		
			Information on this form may be shared with appropriate personnel for health and educational purposes.		