# THE UNIVERSITY OF TENNESSEE AT MARTIN DEPARTMENT OF NURSING
## STUDENT HEALTH EXAMINATION

Name_____________________________________________________ Student ID# ________________________

Phone___________________ Marital Status___________________ Birth Date_______________ Sex □ M □F

Permanent Address________________________________________________________________________________
Street City State ZIP

Emergency Contact________________________________________________________________________________
Name Address Phone #

**Have you ever had:**

□Rheumatic Fever □Nervous Disorders Surgery (Type & Date):_____________________________________
□Diabetes □Kidney Disease _______________________________________________________________
□Dysmenorrhea □Allergies _______________________________________________________________
□Tuberculosis
□Other_____________________________________________________________________________________

Are you taking any medication on long-term/regular basis? □Yes □No
If yes list: ________________________________________________________________________________

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# EXAMINATION

**To be completed by the healthcare provider**

**CODE FOR EXAMINATION:** O-Satisfactory X-Unsatisfactory

| Height | Skin | Heart | Abdomen | Glands |
|---|---|---|---|---|
| Weight | Nose | Lungs | Hernia | Bones/Joints |
| B.P. | Throat | Vision | Kidneys | Posture |
| Pulse | Teeth | Hearing | Reprod. | Feet |

**Urinalysis:** Satisfactory □ Yes □ No **Hematology Report**: Satisfactory □ Yes □ No

Ability to lift and carry up to 50 lbs. without assistance □Yes □No
Ability to push and pull up to 250 lbs □Yes □No
Ability to stand, walk, climb stairs, sit in one place, squat, kneel, reach, bend, crawl and twist □Yes □No
Ability to perform repetitive hand and wrist motion for gripping and squeezing □Yes □No
Ability to use hands and feet together for repetitive, coordinated motions □Yes □No

Has student ever been treated for any psychiatric conditions? □Yes □No
If yes please explain:_______________________________________________________________________

Does student appear to be in good physical and mental health at this time? □Yes □No
If no please explain:_______________________________________________________________________

Provider's Signature_________________________________________________ Date__________________

Revised 4/2015