UNIVERSITY OF NEW MEXICO – TAOS
Certified Nursing Assistant Program
1157 County Road 110
Ranchos de Taos, NM 87557
(575) 737-3744 • FAX (575) 737-3746

DATE: _____

HISTORY AND PHYSICAL EXAMINATION FORM

This page is to be filled out by the student and the second page by the examining practitioner.

You must answer all questions even if the answer is NO, NONE, or N/A. Submit finished form to Rasa O'Donnell, Allied Health Program Specialist.

Name _____ Gender Male / Female / Other

Home address _____ Telephone_____

City/State/Zip _____ Country of birth _____

Email _____ Birth date _____

Person to notify in case of emergency _____ Telephone_____

Health Insurance Company_____ Policy # _____

PAST MEDICAL HISTORY

Describe any past history of medical/surgical illness. _____

_____

Indicate any acute or chronic medical conditions. _____

_____

Do you have or have you had any history of a mental health disorder? _____Please explain._____

_____

Describe any allergies to medications, foods, or other substances. _____

_____

Do you take any medications on a regular basis? _____ Please specify. _____

_____

Do you now or have you in the past habitually used drugs or alcohol? _____

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

Applicant's Signature Date

TO BE COMPLETED BY EXAMINING PRACTITIONER

To the examining practitioner: Please review the history on the previous page of this form and add any pertinent information.

PHYSICAL EXAMINATION

_____ has had a complete history and physical examination on
Student's name

_____. Blood pressure _____Height _____cm Weight _____kg
Date

Findings are as follows:

_____ I find the applicant to be in good physical and mental health with no condition necessitating the continuation of care.

_____ I find the applicant to have a history of the following medical or surgical conditions:
_____

_____ I find the applicant has the following health condition(s) for which continuation of care is required or which may adversely affect his/her educational experience.
(If continued care is required, a complete description of the condition and care required should be included.)
_____
_____

Upon completion of physical assessment and review of the Respirator Medical Evaluation Questionnaire, the patient:
_____ Is able to complete respirator testing for N-95 masks.
_____ Is not able to complete respirator testing for N-95 masks.

Except as noted, the above student is in good physical and mental health and has no problem that might interfere with his/her ability to pursue professional CNA studies.

_____ _____
Name of Practitioner Date

_____ _____
Signature of Practitioner Address

_____ _____
State and License Number Telephone