Name: _____ SS#:_____

New Mexico Junior College
Allied Health and Nursing RN Program
Medical Examination Form

NAME (last, first, MI):	**DOB:** **Age:**	**NURSING STUDENT** **1ST YR. or 2ND YR. (circle)**
SS#:	**Gender: M or F**	**Ethnicity/Race:**
Exam Date:	**Home Phone:**	**Cell Phone:**

Health History: Please circle Yes or No for each of the following and fill in blanks were indicated:

Yes No Asthma	Yes No Head or spinal injuries	Yes No Seizures, fainting, or convulsions
Yes No Claustrophobia	Yes No Rheumatic Heart Disease	Yes No Shoulder, elbow, wrist or hand trouble or injury
Yes No Tuberculosis(TB)	Yes No Painful or swollen joints	Yes No Extensive confinement by illness or injury
Yes No Eczema or psoriasis	Yes No Unusual tiredness or fatigue	Yes No Psychiatric or nervous Disorder **If yes, are you currently on medications?** Yes No
Yes No Hernia	Yes No Heart or blood vessel disease	Yes No Hospitalized? If yes, date: _____
Yes No Diabetes	Yes No Stomach or intestinal disease	Reason hospitalized:
Yes No Nervous stomach	Yes No High Blood Pressure	Yes No Any Surgery(s)
Yes No Heart Trouble	Yes No Currently smoking	If surgery(s), date(s): _____ _____ Diagnosis (surgical):
Yes No Kidney problems	If smoking, # packs per day _____ Circle type smoked: Pipe Cigar Cigarette Vape	Yes No Broken Bones or fractures If yes, date: _____
Yes No Muscular disease	Yes No If not smoking, have you ever smoked?	**Physician Comments:**
Yes No Back pain or injury	If smoked in past, date last smoked ___ Circle type smoked: Pipe Cigar Cigarette Vape	
Yes No Frequent Headaches	**Medications:**	
Yes No Dizzy Spells		
Allergies:		

Student Signature: _____ Date: _____

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Examination Results (to be completed by the physician)

Height: **Weight:**	**Sp02**	**BP**	**P**	**R**	**T**
Near Vision **OD**	**OS**	**OU**			
Far Vision **OD**	**OS**	**OU**			
Corrected Near Vision **OD**	**OS**	**OU**			
Corrected Far Vision **OD**	**OS**	**OU**			
Color Vision **Normal ____ Abnormal ___** **Comment:** **Vision Not Performed**			**Peripheral Vision** **Right 45____ Left 45____** **55____ 55____** **70____ 70____** **85____ 85____**		
Hearing Yes___ No ___ Normal Conversational					
Urinalysis Leukocyte Neg____ Tr____ Sm____ Mod____ Lg____ Protein Neg____ +_____ ++_____ +++_____ ++++/>____ Spec Grav 1.000___ 1.005___ 1.010___ 1.015___ 1.020+___ Blood Neg____ Tr____ Sm____ Mod____ Lg____ Ketone Neg____ Tr____ Sm____ Mod____ Lg____ Glucose Neg____ Tr____ 250____ 500____ 1000/>____			**Comments**		

Examination Area	Circle Normal(N) or Abnormal/Absent(A)	Describe Abnormal or Comment
General and Psychiatric		
General appearance	**Normal (N) Abnormal (A)**	
Mental status	**Normal (N) Abnormal (A)**	
Gait	**Normal (N) Abnormal (A)**	
Skin		
Cyanosis absent	**Normal (N) Absent (A)**	
Eruptions, tumors, rashes absent	**Normal (N) Absent (A)**	
Abnormal pigmentation absent	**Normal (N) Absent (A)**	
Eyes	**Rt._____ Lt._____**	
Lids	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Conjunctiva	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
PERRLA	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Extraoccular movement	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Ears	**Rt._____ Lt._____**	
External ear	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
External auditory canal	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Tympanic membrane	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Nose	**Rt._____ Lt._____**	
Nasal Mucosa	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Mouth		
Tongue, palate	**Normal (N) Abnormal (A)**	
Teeth (caries, absent)	**Normal (N) Abnormal (A)**	
Gums, normal	**Normal (N) Abnormal (A)**	
Tonsils(not enlarged) not if removed	**Normal (N) Absent (A)**	

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Pharynx		
Neck		
Thyroid	**Normal (N) Abnormal (A)**	
Nodules, masses, lymphadenopathy	**Normal (N) Abnormal (A)**	
Range of motion	**Normal (N) Abnormal (A)**	
Heart		
Murmurs	**Normal (N) Absent (A)**	
rhythm	**Normal (N) Abnormal (A)**	
Lungs/Chest	**Rt._____ Lt._____**	
Breath sounds	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
expansion	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Abdomen		
Liver	**Normal (N) Abnormal (A)**	
Kidneys	**Normal (N) Abnormal (A)**	
Spleen	**Normal (N) Abnormal (A)**	
Surgical scars, masses, tenderness	**Normal (N) Abnormal (A)**	
Back		
Kyphosis, scoliosis	**Normal (N) Absent (A)**	
Surgical scars	**Normal (N) Absent (A)**	
Muscle spasms	**Normal (N) Absent (A)**	
Side bending	**Normal (N) Abnormal (A)**	
Forward flexion	**Normal (N) Abnormal (A)**	
Back extension	**Normal (N) Abnormal (A)**	
Straight leg raises	**Rt. Degrees___ Lt. Degrees___**	
Upper Extremities	**Rt._____ Lt._____**	
Grip strength	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Shoulders ROM		
Abduction	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Adduction	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Forward flexion	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Internal rotation	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
External rotation	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Elbows ROM		
Flexion	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Extension	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Supination	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Pronation	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Lower Extremities	**Rt._____ Lt._____**	
Edema	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Able to deep knee bend	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Walk on heels	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Walk on toes	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Hernia		
Umbilical	**Normal (N) Absent (A)**	
Ventral	**Normal (N) Absent (A)**	
Femoral	**Normal (N) Absent (A)**	
Inguinal	**Normal (N) Absent (A)**	
Veins & Arteries	**Rt._____ Lt._____**	
Upper peripheral pulses	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Lower peripheral pulses	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Varicose veins	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
Musculo-skeletal		
Muscle atrophy	**Normal (N) Absent (A)**	
Congenital or acquired impairments	**Normal (N) Absent (A)**	
Nervous System		
Coordination	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	

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Romberg's sign	**Normal (N) Abnormal (A) Normal (N) Abnormal (A)**	
	Rt. _____ Lt. _____	
Bicep reflex	**Normal (N) Absent (A) Normal (N) Absent (A)**	
Achilles reflex	**Normal (N) Absent (A) Normal (N) Absent (A)**	
Patellar reflex	**Normal (N) Absent (A) Normal (N) Absent (A)**	
Other Findings		
Examiner's Name (print)	**Physician's Signature**	
Restriction(s) or Pre-Existing Condition(s)*		
Follow-up Recommended		

Recommendation

The NMJC Allied Health and Nursing RN Program requires the student to be physically and mentally capable of performing all activities required for safe and competent patient care. Please indicate your recommendation in the space provided.

_____ does not have any restrictions or pre-existing condition(s) that will interfere with nursing/clinical performance. Provide a signature below to indicate full release to participate in nursing/clinical program.

Attending Physician Signature _____ Date of Exam _____

Print Physician Name: _____

Office/Clinic Name: _____ Address: _____

City, State, Zip Code: _____

Office Telephone: _____ - _____ - _____ E-mail Address: _____

OR

Based on the findings of this medical examination, this person has a restriction or pre-existing condition that will prevent or interfere with performance and participation in the nursing program*. **I am unable to recommend** this person for participation in the nursing/clinical program at New Mexico Junior College.

_____ has a preexisting condition(s) or restriction(s) that may interfere with nursing/clinical performance.

Attending Physician Signature _____ Date of Exam _____

Print Physician Name: _____

Office/Clinic Name: _____ Address: _____

City, State, Zip Code: _____

Office Telephone: _____ - _____ - _____ E-mail Address: _____