The Rapha School, LLC
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LPN Program Physical

Primary Language: _____ Interpreter Used: __Yes __No Name: _____

Name: _____ Birthdate: ___/___/_____

Primary Phone: (____) - ____ - _____ ___Cell ___Home Email: _____

Address: _____ _____

(Street) (City)

_____ _____

(State) (Zip)

Past Medical/Surgical/Obstetrical/Psychiatric History:

_____

_____

_____

_____

List all prescription or over the counter medications that you take:

_____

_____

_____

_____

_____

Allergies (drugs/food/latex/contrast/other):

___None

___Yes (Please list below)

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Social History:

Do you smoke? __Y __N

Do you use recreational drugs? __Y __N

Do you drink alcohol? __Y __N

Family History of medical complications/disease:

_____

_____

_____

To be completed by physician or nurse practitioner:

Review of Sytems: **Comments:**

Eyes	Neg	Pos	Not Done	
Ears/Nose/Mouth/Throat	Neg	Pos	Not Done	
Cardiovascular	Neg	Pos	Not Done	
Gastrointestinal	Neg	Pos	Not Done	
Respiratory	Neg	Pos	Not Done	
Musculoskeletal	Neg	Pos	Not Done	
Integumentary	Neg	Pos	Not Done	
Neurologic	Neg	Pos	Not Done	
Endocrinology	Neg	Pos	Not Done	
Psychiatric	Neg	Pos	Not Done	
Hematologic/Lymphatic	Neg	Pos	Not Done	
Genitourinary	Neg	Pos	Not Done	

Physical Exam:

Vital Signs: T:_____ BP:_____ Pulse:____ RR:_____ %O_2___L/min Wt____ Ht_____

General Appearance: _____

Head/Eyes/Ears/Nose/Throat: _____

Neck: _____

Heart: _____

Lungs/Chest: _____

Abdomen: _____

Extremities/Back: Able to lift 50 lbs. ___Y ___N

: Able to walk for extended periods of time ___Y ___N

: Able to sit for extended periods of time ___Y ___N

: Able to bend frequently ___Y ___N

: Able to occasionally push carts weighing up to 100 lbs. ___Y ___N

Skin: _____

Neurologic: _____

Lymphatic: _____

Free of communicable diseases in the communicable stage Yes_____ No_____

Rectal Exam: ___Declined ___Not Done :_____

Pelvic/GU Exam: ___Declined ___Not Done :_____

Immunization:	**Date of Immunity:**
Tdap *within the last 10 years	
Mumps	
Measles	
Rubella and/or Rubeola	
Varicella	

Hepatitis B (3 injections, first injection must be done before clinical begins)

First injection ____/_____/_____ Second injection ____/____/_____ Third injection ____/____/_____

The examination must include copies of:

2 Step Mantoux Test (chest x-ray if positive Mantoux Tuberculosis Test)

Date of first test ___/___/_____ Date of second test ___/___/_____

Laboratory Tests

Complete blood count
Urinalysis
Immunizations if no proof of immunity:
- Diptheria
- MMR
- Rubella and Rubeola or documented immunity
- Hepatitis B (3 injections, first injection must be done before clinical begins)
- Varicella

Attending Note: I have personally seen and examined the patient and reviewed with _____ (Student Name) the history, physical examination, laboratory data, and studies.

_____
(Provider Signature)

_____ ___/___/_____ at ___:___am/pm
(Printed Provider Name & Credentials) (Date) (Time)