DNP: Nurse Anesthesia

# Physical Health Assessment

Name: _____ Date of Birth: _____

| System Review | Normal Findings? | Comments/Description |
|---|---|---|
| General Appearance | ☐ Yes ☐ No ☐ Not Examined | |
| HEENT | ☐ Yes ☐ No ☐ Not Examined | |
| Neck | ☐ Yes ☐ No ☐ Not Examined | |
| Chest & Lungs | ☐ Yes ☐ No ☐ Not Examined | |
| Cardiovascular | ☐ Yes ☐ No ☐ Not Examined | |
| Abdomen | ☐ Yes ☐ No ☐ Not Examined | |
| Gastrointestinal | ☐ Yes ☐ No ☐ Not Examined | |
| Genitourinary | ☐ Yes ☐ No ☐ Not Examined | |
| Musculoskeletal | ☐ Yes ☐ No ☐ Not Examined | |
| Extremities | ☐ Yes ☐ No ☐ Not Examined | |
| Integumentary | ☐ Yes ☐ No ☐ Not Examined | |
| Endocrine | ☐ Yes ☐ No ☐ Not Examined | |
| Neurological | ☐ Yes ☐ No ☐ Not Examined | |
| Psychological | ☐ Yes ☐ No ☐ Not Examined | |
| VISION SCREEN | ☐ Yes ☐ No ☐ Requires Specialist | |
| COLOR VISION SCREEN | ☐ Yes ☐ No ☐ Requires Specialist | |
| HEARING SCREEN | ☐ Yes ☐ No ☐ Requires Specialist | |

Medical history reviewed? ☐ Yes ☐ No

Limitations or restrictions on activities? ☐ Yes ☐ No

Does this person use adaptive equipment? ☐ Yes ☐ No

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By signing this form, I certify that I have examined the above-named individual. This individual is:

- Free of any health impairment that may pose risk to others, and which might interfere with the individual's capability to function in a clinical setting
- Physically able to withstand the duties associated with patient care
- Not contagious
- Able to lift up to 50 pounds

*Provider Printed Name* *Date*

*Name of Practice*

*Practice Address* *Telephone Number*

*Signature (Must be a Physician, Nurse Practitioner or Physician's Assistant)*

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