PHYSICIAN HISTORY & PHYSICAL EXAM

NOTE: If space provided in any area is insufficient, use reverse side for additional notes.

Community Name

DIAGNOSES	Primary	Secondary	History (Chronic)	History (Resolved)

ALLERGIES (include medication, food, other):

Summary of present illness:

PAST MEDICAL HISTORY

Previous mental illness or mental retardation history

☐ No ☐ Yes, Date: ___________

Describe: ___________

Seizure disorder ☐ No ☐ Yes, Date: ___________

Tuberculosis ☐ No ☐ Yes, Date: ___________

Fractures ☐ No ☐ Yes, of ___________

Other significant issues:

PAST SURGERY

Procedure	Date	Reason, if known

PERSONAL HABITS

Smokes: ☐ No ☐ Yes, amount: ___________

Alcohol intake: ☐ No ☐ Yes, amount: ___________

Substance abuse: ☐ No ☐ Yes

Describe: ___________

IMMUNIZATION HISTORY

Pneumovax	Flu Vaccine	Tetanus	Hepatitis A	Hepatitis B	Hepatitis C
Date: ___	Date: ___	Date: ___	Date: ___	Date: ___	Date: ___

Other:

DIAGNOSTIC STUDIES & SCREENING

MANTOUX or TUBERCULIN SKIN TEST Date given: ___________ Results: ___________

Date given: ___________ Results: ___________

Chest X-Ray Date: ___________ Results: ___________

Other:

CURRENTLY RECEIVING REHAB SERVICES (i.e., PT, OT, ST) ☐ No ☐ Yes if yes, specify:

MANAGEMENT OF MEDS

Can self administer: ☐ No ☐ Yes

Requires supervision with self administration: ☐ No ☐ Yes

Requires medication administration: ☐ No ☐ Yes

Other requirements: ___________

PHYSICAL EXAMINATION

Age	Height	Weight	B/P	Temp.	Pulse	Resp.

Neurological	Abdomen
Cognitive Function	Genitalia
Head/Neck	Urinary
Eyes/Ears/Nose/Throat	Pelvic
Oral Cavity (use of dentures)	Rectal
Chest	Extremities
Heart	Musculoskeletal
Lungs	Skin

☐ Physical condition essentially unchanged from physical exam of (date): ___________

☐ Resident shows NO EVIDENCE OF COMMUNICABLE DISEASE in an infectious stage

☐ *Assisted Living Only:* Is the resident appropriate for Assisted Living ☐ Yes ☐ No (if no, specify)

Comment: ___________

☐ *More narrative comments on reverse*

PROGNOSIS ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ End-stage disease, 6 or fewer months

AWARE OF DIAGNOSIS ☐ Yes ☐ No If no, why: ___________

REHABILITATION POTENTIAL ☐ Good ☐ Fair ☐ Poor ☐ None ☐ Other: ___________

PROJECTED DISCHARGE from date of this exam: ☐ NO ☐ Unlikely ☐ Uncertain ☐ Within 30 days ☐ Within 31-90 days ☐ Within _______ days

Physician or Designee Signature/Title	License No.	Address	Phone ( )	Date

Resident Name	Clinical Record #	Room #	Physician (Print Name)

SAMPLE

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Resident Name	Clinical Record #	Room #

Additional Comments

Resident Name	Clinical Record #	Room #

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SAMPLE

Additional Comments
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