



PREADMISSION & ANNUAL MEDICAL HISTORY AND PHYSICAL

Name:		
Address:		
Telephone Number:	Date of Birth:	
Has applicant/resident been in a: Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/>		
For what reason?		
Are you the applicant's/resident's regular physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		
List all medications which applicant/resident is presently taking:		
Please provide prescriptions for all medications, including over-the-counter, and any adaptive equipment (if needed) prior to move in.		
History		
History Of:		
Allergies		
Diabetes	Cancer	Type
Cardiac	Respiratory Illness	Tuberculosis
		Prostate Disease
Paralysis/ Weakness	Where	
Fractures	Location	When
Surgeries	When	Reason
Chronic Illness		
Mental And Emotional Health		
Prosthesis		
Dietary Needs (Please Circle One):		
NO SALT ADDED	NO CONCENTRATED SWEETS	REGULAR

Physical Examination

Height		Weight	Temperature	Blood Pressure
Head	Scalp	Nose	Gums	Ears
	Eyes	Throat	Tongue	Teeth
Neck		Nodes	Thyroid	
Chest		Breasts	Lungs	
Abdomen	Hernia	Genitalia	Rectum	
Extremities		Skin		
Neurological:				
Diagnosis:				
Remarks and Recommendations:				
Special Care Needs:				
Physician (Please Print)			Date of Examination	
Full Address			Telephone Number	
Physician Signature _____				