Medical History Assessment

Each applicant for residence in the Generations community must submit this medical form, completed by the family physician. Data must be current within thirty (30) days of submitting application.

Physicians, please type or print all requested information.

Applicant's Name: _____

Applicant's Address: _____

City: _____ State: _____ Zip: _____

Applicant's County of Residence: _____

Physician's Title/Name: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Applicant's Date of Birth: (month)_____ (day)_____ (year)_____ I have known applicant for _____ years

Date of Last Exam: (month)_____ (day)_____ (year)_____ Applicant's Height: _____ Weight: _____

Are infectious or contagious diseases present? ☐ yes ☐ no If yes, please explain: _____

_____

_____

Applicant: A. Walks without help: ☐ yes ☐ no

B: Needs help of: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Another person

Is applicant able to take medications without help/supervision? ☐ yes ☐ no

Applicant: A. Can climb _____ (#) of steps safely without assistance.

B: Has these additional disablilities/handicaps/physical limitation: _____

_____

Applicant: A: Is sensitive to food and /or airborne allergies: ☐ yes ☐ no If yes, please explain: _____

B: Requires a special diet: ☐ yes ☐ no If yes, please explain: _____

Is applicant allergic to any medicines or treatments: ☐ yes ☐ no If yes, please explain: _____

Applicant needs daily help from: ☐ Sitter ☐ Aide ☐ No Help

What type of help(administration of medicine, bathing, tolieting, general oversight, grooming, other)?:

Does the applicant have any symptoms of Alzheimer's Disease and/or any other related dementia?
☐ yes ☐ no If yes, please explain: _____

To your knowledge does the applicant have a history of wandering? ☐ yes ☐ no If yes, please explain:

Does applicant have full control over bladder and/or bowel functions: ☐ yes ☐ no If yes, please explain:

Can the applicant manage/use toxic agents in their room? Example: window cleaner, air freshner and colorx wipes) ☐ yes ☐ no

Is the applicant able to enter and exit the facility in the event of an emergency, whether it is independently, wheelchair/walker, or staff assistance? ☐ yes ☐ no

Are there any conditions or habits which would adversely affect the well being of others in the facility?
☐ yes ☐ no If yes, please explain: _____

Does the applicant have any dental issues? ☐ yes ☐ no If yes, please explain: _____

Does the applicant have any podiatric issues? ☐ yes ☐ no If yes, please explain: _____

Has applicant ever had (please indicate "C" for current, "P" for past, "N" for No):

___ Angina	___ Arthritis	___ Asthma	___ Bleeding tendency	___ Blood Clot
___ Cancer/Tumor	___ Depression	___ Dialysis	___ Frequent colds/infections	___ Diabetes
___ Fractures	___ Headaches	___ Frequent falls	___ Glaucoma	___ Heart Attack
___ Kidney Disease	___ Stomach Problems	___ Pacemaker	___ Tuberculosis	___ Ulcers
___ Kidney Problems	___ Anxiety/nervous disorders		___ Sinusitis	___ Latex Allergy
___ Parkinsons	___ High Blood Pressure		___ Congestive Heart Failure	___ Stroke
___ Atrial Fibrillation	___ High Cholesterol		___ Oxygen (# of Liters___)	___ Acid Reflux

Additional pertinent evaluation of applicant's medical history (please include all major surgeries): _____

Two-step PPD:

Step 1 Date given: _____ Date read: _____ Site: _____ Results in MM: _____

Step 2 Date given: _____ Date read: _____ Site: _____ Results in MM: _____

Given by: _____

Does applicant have an Advanced Directive: ☐ yes (must have copy) ☐ no

Does applicant have a Do Not Resuscitate (DNR): ☐ yes (must have copy) ☐ no

A community residental care facility provides room, board, and a degree of personal assistance in the activity of daily living. Can this applicant be cared for in such a facility? ☐ yes ☐ no

Physician's signature: _____ Date: _____

Physician's name (printed): _____

Physician's address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Admission Medication List

Patient Name: _____ Date of Birth: _____

Medication	Directions	Qty Disp	Refills

_____ _____ _____

Dispense As Written Substitution Permitted Date

MD Print Name: _____

MD Address: _____ Phone: _____

NPI: _____ DEA _____ SC Lic Number: _____

**** ALL INFORMATION MUST BE PROVIDED FOR THIS TO BE A LEGAL PRESCRIPTION***