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: ____________

County: ____________________

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 disabilities/handicaps/physical limitation: ____________________

____

____

Does applicant wear: ☐ Glasses ☐ Dentures ☐ Hearing aids ☐ Other prosthesis (please explain): ______

______

______

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 list: ______

______

______

Please list all medicines currently prescribed for applicant, with dosage and frequency to include over-the-counter, PRNs and refills(Please list on the separate sheet provided_ physicians please sign medication sheet): ______

______

______

Applicant needs daily help from: ☐ Sitter ☐ Aide ☐ LPN ☐ RN ☐ No help

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

______

______

Does applicant show signs of confusion, dementia or Alzheimer's: ☐ yes ☐ no If yes, please elaborate: ______

______

______

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

____

____

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

__ Angina	__ Arthritis	__ Asthma	__ Bleeding tendency	__ Blood clot
__ Cancer	__ Depression	__ Dialysis	__ Frequent colds/infections	__ Diabetes
__ Fractures	__ Headaches	__ Frequent falls	__ Glaucoma	__ Heart Attack
__ Kidney Disease	__ Oxygen therapy	__ Pacemaker	__ Tuberculosis	__ Ulcers
__ Sinusitis	__ Anxiety/nervous disorders		__ Other ________	

____

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 (copy required) ☐ no

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

____

Can applicant function at assisted living level: ☐ yes ☐ no

Physician's signature: ________________________ Date: ________

Physician's name (printed): ________________________

Physician's address: ________________________

City: ________________ State: ________ Zip: ________

Phone: ________________ Fax: ________________ E-mail: ________________

Admission Medications List

GENERATIONS OF CHAPIN
431 EAST BOUNDARY ST
CHAPIN, SC 29036
(803) 345-1911

PATIENT NAME ______________________________ DOB ____________________

MEDICATION	DIRECTIONS	QTY DISP	REFILS

MD SIGNATURE AND DATE

____________________ DISPENSE AS WRITTEN

____________________ SUBSTITUTION PERMITTED

____________________ DATE

MD PRINT NAME ______________________________

MD ADDRESS ______________________________ PHONE ____________________

NPI ____________________ DEA ____________________ SC LIC NO. ____________________

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