



# Sharing the Caring Adult Day Services Center Medical Exam Form

## HISTORY AND PHYSICAL

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Physical Exam \_\_\_\_\_

Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Second Contact Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

### ALLERGIES

### HOSPITALIZATION OR SURGERY DATE

Reason \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### CURRENT MEDS/TREATMENTS/THERAPIES

Meds: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Treatments/Therapies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is client allowed Acetaminophen Ibuprofen \_\_\_\_\_

Is client able to self-administer meds? YES NO \_\_\_\_\_

### DIET/DIET RESTRICTIONS

Diet: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

Headache	MI	Hepatitis	Venereal disease
Hypertension	Orthopnea	Ulcer	Anemia
Stroke/TIAs	Hyperlipidemia	GI disorder	Blood disorder
Epilepsy	Congestive heart failure	Bowel irregularity	Gout
Shortness of breath	Arrhythmia	Renal failure	Rheumatic fever
Heart palpitations	Allergies/hay fever	Kidney disorder	Diabetes
Chest pain/angina	Asthma	GU disorder	Endocrine disorder
Dizziness/fainting	COPD	Sexual dysfunction	Arthritis
Peripheral vascular disease	Tuberculosis	Prostate disease	Osteoporosis
Coronary artery disease	Liver disease	Incontinence	Cancer _____

## MENTAL STATUS

Orientation	Behavior	Cognition
_____	_____	_____
_____	_____	_____
_____	_____	_____

## TB TESTING AND COMMUNICABLE DISEASE STATEMENT

Complete A or B

A. Date of last Tuberculin Skin Test \_\_\_\_\_ Results \_\_\_\_\_  
(must be within 2 years)

B. Date of last chest X-ray \_\_\_\_\_

Check One:

**Client is free of communicable disease.**

Client has a communicable disease but can attend day care with specific precautions.

Which are: \_\_\_\_\_

**PHYSICAL DISABILITY/SENSORY FUNCTIONING ASSESSMENT**

Physical Disabilities:

Aids/Devices:

Sensory Functioning:

Aids/Devices:

**PHYSICAL EXAM**

Temperature

Pulse

BP

Height

Weight

Respiration

GENERAL APPEARANCE

**NOTES**

Skin		
HEENT		
Neck		
Thyroid		
Lymph nodes		
Veins/carotid		
Chest		
Lungs		
Heart		
Abdomen		
Genital		
Rectal		
Extremities		
Joints		
Clubbing/cyanosis		
Peripheral pulses		
Edema		
Neurologic		

**IMPRESSIONS**

Primary Diagnosis:

Secondary Diagnoses:

I find that \_\_\_\_\_ is able to attend the Adult Day Services Center.  
*(client's name)*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please print name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

