



**PHYSICIAN'S HEALTH ASSESSMENT / MEDICAL INFORMATION AND
AUTHORIZATION FOR TREATMENT**

Participant Name: _____ Date: _____

D.O.B.: _____ Age: _____ Sex: _____
Height: _____ Heart Rate: _____ Temperature: _____
Weight: _____ Blood Pressure: _____ Respirations: _____

Primary Diagnosis: _____ ICD-10: _____
Secondary Dx: _____ ICD-10: _____
Other Dx: _____
Prognosis: _____
Allergies: _____

Constitutional:	Musculoskeletal:
Eyes:	Integumentary:
Ears / Nose / Mouth /Throat:	Neurological:
Cardiovascular:	Psychiatric:
Respiratory:	Endocrine:
Gastrointestinal:	Hematologic / Lymphatic:
Genitourinary:	Allergic/Immunologic:

ASSISTIVE EQUIPMENT USED:

- Walker Quad Cane Single point cane Wheel chair
 Glasses Hearing Aid Dentures Other: _____

Mental Health Status:

- Confusion Hallucinations Disorientation Insomnia
 Depression Anxiety Delusions Wandering
 Suspiciousness Memory Loss Loss of Interest Impaired Judgment
 Loss of Interest Loss of Appetite Alcoholism Drug Abuse
 Other: _____

Diet: Does your patient require a **special diet**? No Yes (Please specify): _____

Activity Order: Ad Lib / Light exercises in sitting position / Assisted transfers / other: _____

Falls Risk: Is this person at increased risk for falls? _____

Other Pertinent Health History: _____

TB test (Optional)	<input type="checkbox"/> skin test	<input type="checkbox"/> chest x-ray:
	Date given: _____ Date read: _____	Date: _____
	Read by: _____	Results: _____

Vaccines (Optional)	<input type="checkbox"/> flu vaccine	<input type="checkbox"/> pneumonia vaccine
	Date: _____	Date: _____

OTC Medication STANDING ORDERS per package instructions: (Please check)

Tylenol 500 mg <input type="checkbox"/> Y <input type="checkbox"/> N	Tums <input type="checkbox"/> Y <input type="checkbox"/> N
Ibuprofen 200 mg <input type="checkbox"/> Y <input type="checkbox"/> N	Mylanta <input type="checkbox"/> Y <input type="checkbox"/> N
Aspirin 325 mg <input type="checkbox"/> Y <input type="checkbox"/> N	Simethicone <input type="checkbox"/> Y <input type="checkbox"/> N
Benadryl 25 mg <input type="checkbox"/> Y <input type="checkbox"/> N	Kaopectate <input type="checkbox"/> Y <input type="checkbox"/> N
Dextromethorphan <input type="checkbox"/> Y <input type="checkbox"/> N	Colace <input type="checkbox"/> Y <input type="checkbox"/> N
Guaifenesin <input type="checkbox"/> Y <input type="checkbox"/> N	Milk of Magnesia <input type="checkbox"/> Y <input type="checkbox"/> N

Additional orders or comments: _____

