

**PHYSICIAN HISTORY AND PHYSICAL**

This form is to be completed by a physician licensed in the State of \_\_\_\_\_.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**PRESENT CONDITION**

Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Head / Oral \_\_\_\_\_  
Neck \_\_\_\_\_  
Chest \_\_\_\_\_  
Cardiovascular \_\_\_\_\_  
Abdominal \_\_\_\_\_  
Genitourinary \_\_\_\_\_  
Skin \_\_\_\_\_  
Bones and Joints \_\_\_\_\_  
Glandular \_\_\_\_\_  
Neuromuscular \_\_\_\_\_

**RESULTS OF TWO-STEP PPD OR ONE STEP PPD WITH CURRENT CHEST X-RAY**

Step One Date and Results \_\_\_\_\_ Step Two Date and Results \_\_\_\_\_  
Chest X-Ray Date \_\_\_\_\_ (Current within 1 year of admission - attach report)  
Chest X-Ray Result \_\_\_\_\_

**GENERAL**

YES      NO

\_\_\_\_\_      \_\_\_\_\_ Does the patient have a history of mental illness, substance abuse or other condition which could present a danger to self or others?

\_\_\_\_\_      \_\_\_\_\_ Dementia: Please describe. \_\_\_\_\_

\_\_\_\_\_      \_\_\_\_\_ Is the patient able to recognize and respond appropriately to emergency situations without verbal or limited physical assistance?

**PHYSICIAN'S RECOMMENDATION**

YES      NO

\_\_\_\_\_      \_\_\_\_\_ Individual is appropriate to live in a licensed **Assisted Living Community** where personal care needs can be met by non-nursing personnel, supervised by a licensed nurse.

\_\_\_\_\_      \_\_\_\_\_ Individual is appropriate for a special care unit providing services to individuals with dementia or related disorders. This unit may be secured.

**PNEUMOCOCCAL VACCINE**      Date \_\_\_\_\_

**FLU VACCINE**      Date \_\_\_\_\_

**DIAGNOSES AND SUMMARY OF HEALTH CONDITIONS**

**PHYSICIAN NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_

**PHYSICIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_