

## MEDICAL HISTORY FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

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

Prognosis: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Mental Status: \_\_\_\_\_

Rehabilitative Status / Prognosis:

\_\_\_\_\_

\_\_\_\_\_

Rehabilitative Aids and /or Appliances (including Cardiovascular, Gastrointestinal or

Genitourinary): \_\_\_\_\_

Is this person able to take his/her own medications? \_\_\_\_ Yes \_\_\_\_ No

Is this person able to take care of his/her own personal needs? \_\_\_\_ Yes \_\_\_\_ No

If not, what assistance is needed? \_\_\_\_\_

\_\_\_\_\_

Is this person continent of bowel? \_\_\_\_ Yes \_\_\_\_ No      Of Bladder? \_\_\_\_ Yes \_\_\_\_ No

Activities restricted: \_\_\_\_\_

Diet: (Circle) Regular; No Added Salt; No Concentrated Sweets; Mechanically Soft

Allergies? \_\_\_\_ Yes \_\_\_\_ No    Foods: \_\_\_\_\_    Drugs: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Weight: \_\_\_\_\_

How often should this person be seen by you? \_\_\_\_\_

How often should this person attend daycare? \_\_\_\_\_

To the best of your knowledge, does this person have any communicable disease? \_\_\_\_\_

If so, please indicate status: \_\_\_\_\_

**Florida Department of H.R.S. requires (within 45 days prior to admission to Adult Day Care Center) documentation of freedom from Tuberculosis according to acceptable screening methods. (May be signed by Nurse Practitioner or Public Health Unit Staff)**

\* TB Test / Chest X-ray      \* Date Given: \_\_\_\_\_      \* Date Read: \_\_\_\_\_  
(Circle One)

\* Results: \_\_\_\_\_

\* Physician's Signature \_\_\_\_\_

Medications

Dosage and Frequency

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize that the medications listed above may be administered by licensed nursing personnel while the above named individual attends St. Mary Magdalen Adult Center.

\* Physician's Signature \_\_\_\_\_