Return Form to:_____

Admission Medical Information Form

Part I: To Be Completed by Family or Staff

Name:_____ SSN:_____
Last First Middle

Date of Birth:_____ Sex: M F Race:_____ Marital Status:_____

Home Address:_____
Number/Street City State Zip

Phone Number:_____

Last Time Hospitalized:_____
Date(s) Reason

Name and Location of Hospital:_____

Last Visit to Physician:_____
Date(s) Reason

Name and Address of Primary Physician:_____

(Comment: YES, NO, SEVERE)

Frequent headaches_____
Difficulty with vision_____
Difficulty with hearing_____
Tuberculosis_____
Pneumonia_____
Asthma or hay fever_____
Persistent cough_____
Cough producing blood_____
Pain in chest_____
Smokes_____
Alcohol consumption_____
Unprescribed drugs_____
Fatigue_____
Anemia_____
Frequent colds/infections_____
Nervous breakdown_____
Convulsions_____
Fainting_____
Jaundice_____
High blood pressure_____
Spasticity of extremities_____
Frequent vomiting_____
Measles (2 weeks)_____
Measles (3 days)_____

Chicken pox_____
Shortness of breath_____
Fever or night sweats_____
Unusual gain or loss of weight_____
Burning on urination_____
Frequent indigestion_____
Diarrhea or constipation_____
Diabetes_____
Special diets_____
Speech defect_____
Color blindness_____
Venereal disease_____
Rheumatic fever_____
Blood in urine_____
Kidney disease_____
Accidents_____
Fractures_____
Arthritis_____
Hernia_____
Transfusion_____
Incontinence of bowel_____
Incontinence of bladder_____
Nosebleeds_____
Mumps_____

Menstruating? ☐ Yes ☐ No Age Began:_____

Frequency:_____ Duration:_____ Severity:_____

Any Female Surgery? ☐ Yes ☐ No If yes, what?_____

Any Pregnancies?_____

Birth Control? ☐ Yes ☐ No If yes, type:_____

Seizures? ☐ Yes ☐ No Type:_____ Frequency:_____

Allergies (food/medicine/other)? ☐ Yes ☐ No

Type:_____ Severity:_____

Type:_____ Severity:_____

Accidents (Specify):_____

Operations for (Specify):_____

Fractures of (Specify):_____

Developmental History:

Prenatal:_____

Natal:_____

New Born:_____

Childhood:_____

Adulthood:_____

Ambulation:

Ambulatory ☐ Yes ☐ No Non-ambulatory ☐ Yes ☐ No

Type of assistance device:_____

CHECK ALL THAT APPLY:

Able to climb onto: Van_____ School Bus_____ Car_____ Transit Bus_____

If assistance is required, please explain:_____

Part I Completed By:_____ Date:_____

Relationship to Client:_____

Admission Medical Information Form

Part I: Physical Examination (To Be Completed by physician)

Name:_____ SSN:_____
Last First Middle

Vital signs: BP_____ P_____ R_____ T_____
Blood Type (if known)_____
Height (w/o shoes):_____ Weight (with/without clothes):_____
General Appearance:_____
Nutritional Status:_____

Check and Note Abnormalities for the Following:

Head_____ Glands/Thyroid_____

Skin_____ Heart/Cardiovascular_____

Eyes: Vision Screening: Right Eye_____ Left Eye_____
Test Used:_____
Conjunctiva_____ Sclera_____ Cornea_____
Pupils_____ Lens_____ Fundi_____

Ears: Auditory Acuity: Right_____ Left_____ Bilateral_____
Test Used:_____
Canals_____ Drums_____

Abdomen_____ Nodes_____

Nose_____ Skeletal System_____

Teeth/Gums_____ Breast_____

Neck_____ Gyn_____

Lungs_____ Rectal_____

Chest_____ Joints_____

Genitalia_____ Extremities_____

Neurological:
Orientation_____ Cranial Nerves_____
State of Consciousness_____ DTR_____
Pathological Reflexes_____ Muscle Strength_____
Gait_____ Tone_____
Involuntary Movements_____

Seizures? ☐ Yes ☐ No Description_____ Last seizure/frequency_____

Physician managing disorder (if other than examining physician)_____
Last Neurological Evaluation_____ Anticonvulsant Levels_____

Prosthetic Devices? ☐ Yes ☐ No Is there any physical, emotional, mental reason why this person cannot board or debark a bus/van? ☐ Yes ☐ No If yes, please explain_____

Admission Medical Information Form - Tests

Part III: Lab Studies, Immunizations and Medications (To Be Completed by Physician)

Name:_____ SSN:_____
Last First Middle

A. Laboratory Studies

Tuberculin: Date of last PPD:_____ Results:_____
Date of last chest X-ray:_____ Results:_____

Please attach PPD results. If results are positive, please attach chest x-ray results. Test results must be within one year.

Liver Function: (Tests of liver function **REQUIRED** if client is receiving or has received anticonvulsant or psychotropic medication within the past year.)

SGPT_____ Date_____
SGOT_____ Date_____
CPK_____ Date_____
LDH_____ Date_____
Alkaline Phosphatase_____ Date_____
Shigella_____ Date_____
Salmonella_____ Date_____
Ova & Parasites_____ Date_____

Hepatitis B Screening: (Note: If client has developed antibodies, either naturally or through vaccination, it is not necessary to repeat this screening.) Date of Screening:_____

Surface antigen: Negative_____ Positive_____
Surface antibody: Negative_____ Positive_____
Core antibody: Negative_____ Positive_____

Hematocrit_____ Last PAP Test Date:_____ Results _____
(Note: To be done every three years unless otherwise prescribed.)

U/A: Sugar_____ Albumen_____
Ph._____ SP.Gravity_____
Acetone_____ Microscopic_____

B. Immunization

Date of last Tetanus/Diphtheria Booster:_____ (Should be within last ten years.)
Heptavax B Vaccine:
Dose #1 Date_____
Dose #2 Date_____
Dose #3 Date_____
Small Pox Date_____ Poliomyelitis Date_____
Salk or Sabin Date_____ Measles Date_____
Rubella Date_____

C. Prescribed Medications: ☐ Yes ☐ None

(If medications are prescribed, please complete attached *Physician's Medication Order Form, C-41*. If psychotropic medications a prescribed, please complete *Form C-53 Screening Scale for Tardive Dyskinesia* also.)

Admission Medical Information Form

Part IV: Diagnosis and Follow Up (To Be Completed by Physician)

Name:_____ SSN:_____

Last First Middle

A. Diagnosis:_____

_____

_____

B. This individual is free of communicable diseases: ☐ Yes ☐ No (If "NO" please explain)_____

_____

_____

C. If further examination and/or services by specialist(s) are indicated to complete examination and/or diagnosis, specify for which area(s):_____

_____

_____

D. Limitations:

Dietary:_____

Physical:_____

Other:_____

E. Recommendations (including diet):_____

_____

_____

F. Other Comments:_____

_____

_____

_____

Examining Physician (please print or type):_____

Physician's Signature:_____ Date:_____

Address:_____ Phone No:_____

FORM COMPLETED BY (IF OTHER THAN PHYSICIAN):_____