MEDICAL HISTORY AND ADMISSION EXAMINATION

Diagnoses: Primary:_____

Secondary:_____

Chronic:_____

History:_____

Allergies (food, medications, environmental, other):_____

CURRENT MEDICAL STATUS (Onset date, complaints, etc.)	PAST SURGERIES/PROCEDURES
	Surgery/ Date:_____ Procedure:_____ Reason:_____ Surgery/ Date:_____ Procedure:_____ Reason:_____ Surgery/ Date:_____ Procedure:_____ Reason:_____ Surgery/ Date:_____ Procedure:_____ Reason:_____

PHYSICAL EXAMINATION

Height:_____ Weight:_____ Temp:_____ Pulse:_____ Resp.:_____ B/P:_____

SYSTEMS	NEGATIVE	ABNORMAL (specify)
Head/Neck	❑	
Neurological	❑	
Oral cavity	❑	
Eyes/Ears/ Nose/Throat	❑	
Chest/Lungs	❑	
Breasts	❑	
Abdomen	❑	
Pelvic	❑	
Genitalia	❑	
Urinary	❑	
Rectal	❑	
Extremities	❑	
Skin	❑	
Musculoskeletal	❑	

IMMUNIZATIONS: Influenza - Date:_____ PPSV23 - Date:_____ PCV20 - Date:_____ PCV15 - Date:_____

Tetanus - Date:_____ Herpes Zoster - Date:_____ COVID-19 Booster:_____ Date:_____

Other:_____ Date:_____

TB TESTING: 1st Mantoux - Date:_____ Results:_____ 2nd Mantoux - Date:_____ Results:_____

Chest X-ray - Date:_____ Results:_____ Other:_____ Date:_____ Results:_____

HEALTH CONCERNS: Smokes: ❍ No ❍ Yes Uses chewing tobacco: ❍ No ❍ Yes Drinks alcoholic beverages: ❍ No ❍ Yes

Other:_____

Rehabilitation Potential: ❍ Good ❍ Fair ❍ Poor ❍ Other:_____

Prognosis: ❍ Good ❍ Fair ❍ Poor ❍ End-stage/Terminal ❍ Other:_____

Aware of Diagnosis: ❍ Yes ❍ No, explain:_____

Free from Communicable Disease: ❍ Yes ❍ No, explain:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

MEDICAL HISTORY AND ADMISSION EXAMINATION

RECOMMENDATIONS

COMMENTS/ADDITIONAL NOTES

Physician/Physician Extender Signature/Title:_____ Date:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed