Print Form

AFRH
The Premier Retirement Community for Retired Veterans

Armed Forces Retirement Home
MEDICAL EXAMINATON FORM

NAME:		**AGE:**	
ADDRESS:		**DOB:**	Month Day Year
CITY:			
STATE:		**SEX:**	☐ M ☐ F
ZIP CODE:			
PHONE #:			

What are your living arrangements: ☐ Own home ☐ Relative's home ☐ Other

HEALTH HISTORY: (This page to be completed by applicant)
Have you ever had any of the following? Please check Yes (Y) or No (N)

Y	N	Condition	Y	N	Condition	Y	N	Condition
☐	☐	Asthma	☐	☐	Ulcers	☐	☐	Seizures
☐	☐	Kidney	☐	☐	Head or spinal injury	☐	☐	Allergy(s)
☐	☐	Tuberculosis (or exposure to TB)	☐	☐	Psychiatric or Mental Health Problems			
☐	☐	Diabetes	☐	☐	High blood pressure			
☐	☐	Muscular disease	☐	☐	Cancer			
☐	☐	Cardiovascular disease	☐	☐	Arthritis			

Have you been hospitalized in the past five years? If so please explain the reason for hospitalization (including psychiatric) in the space below or add an extra page.

List medications you're currently taking:	9)
1)	10)
2)	11)
3)	12)
4)	13)
5)	14)
6)	15)
7)	16)
8)	17)

OVER

MEDICAL EXAMINATION: (This page to be completed by medical examiner)

Please answer all questions: The information that you provide to the Armed Forces Retirement Home (AFRH) is to be used ONLY as a basis for certification for residency at AFRH.

*Please check appropriate box

Height			Self	Assist	Total
Weight		Eating			
Blood pressure	/	Bathing/Hygiene			
Pulse rate		Medication			
Temperature		Ambulation			

Mental status/Behavior: circle Yes (Y) or No (N). If Yes, indicate frequency: 1=seldom; 2=frequent; 3=always

Y N (1,2,3) Oriented	Y N (1,2,3) Comatose	Y N (1,2,3) Hostile
Y N (1,2,3) Forgetful	Y N (1,2,3) Confused	Y N (1,2,3) Combative
Y N (1,2,3) Depressed	Y N (1,2,3) Wanders	

Drug and/or Alcohol Abuse: Please explain current indications or history of alcohol misuse, drug misuse or addictions:

Activities of Daily Living: Check appropriate box(es).

☐ Verbal	☐ Impaired vision (glasses)
☐ Non-verbal	☐ Impaired hearing (hearing aid)
☐ Bowel Incontinence	☐ Bladder Incontinence
☐ Dentures	☐ Urinary Catheter

Level of Care Determination: Check appropriate box.

1) ☐ Independent living

2) ☐ Assisted care-Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum of assistance

3) ☐ Skilled care -Includes professional nursing care and assessment on a daily basis due to a serious condition, which is unstable, or a rehabilitative therapeutic regime requiring a professional staff

PPD Screening Test for Tuberculosis results (circle results): NEG POS

Date PPD results completed:_____

If positive, what was the conversion date:_____

Medical Professional Signature: _____

If positive please provided chest x-ray results and findings:_____

Date of Chest x-ray:_____

***Applicant is required to take a PPD Screening Test for Tuberculosis for admission to AFRH.**

Examiner Please circle one:

Physician Certified PA Certified Nurse Practitioner

_____

Type/Print Name

_____

Signature Date

Address: _____

State & Zip Code:_____

Phone number: _____

Contact and mailing information:

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