Meadowood Retirement Community
CONFIDENTIAL HEALTH INFORMATION
To be completed by Physician

Name of Applicant_____
(Last) (First) (Middle)
Date of Examination_____ Birth Date_____ M_____F_____

Current: Blood Pressure_____ Pulse _____Weight_____ Height_____

How long have you cared for this patient? _____

Check any of the following conditions which apply to your patient:

_____Asthma
_____Cancer
_____Heart Problems
_____Smoking
_____Diabetes
_____High Blood Pressure
_____Arthritis
_____Drug/Alcohol addiction
_____Emphysema
_____Emotional Problems
_____Contagious diseases

Please explain further any conditions that are checked above:_____

_____

_____

Please record abnormalities:

Skin_____
Neck_____
Lungs_____
Heart_____
Mouth_____
Breasts_____
Abdomen_____
Extremities_____

History of Serious Illness:

Infections:_____ Hypertension:_____
Operations:_____
Cancer with dates treated:_____

Allergies (please be specific)_____
_____

Current medications of patient:_____
_____
_____

Special Diet, if any_____

Special Aids_____

Please circle appropriate description:
Alert Well oriented Confused Senile Severely Senile

Is resident fully able to live independently and to care for self? _____Yes _____No
Please comment on resident's ability to live independently_____
_____
_____

Do you detect evidence of a condition that probably will lead to the need for prolonged infirmary care?
If yes, please explain_____

_____

If patient is moving from out-of-town, who will be the local physician?_____

Is applicant ambulatory? (with or without aids such as cane or walker?)	____yes	____no
Is applicant capable of bathing and dressing without assistance?	____yes	____no
Can applicant manage toilet facilities alone?	____yes	____no
Can applicant move in and out of bed/chair without assistance?	____yes	____no
Is applicant able to walk 500ft at least once a day without assistance?	____yes	____no
Does applicant arrange his/her own medical care and prescriptions?	____yes	____no
Does applicant comply with medication schedules and any special diets?	____yes	____no

On the basis of my physical findings, no disease or condition is present that may impair the health or comfort of other residents at Meadowood Retirement Community. This applicant is_____ is not_____ able to live alone and maintain a daily schedule without assistance and is ambulatory.
Any additional comments:_____

_____

_____

Physician's Signature_____ Date_____

Printed Name and address/phone number of physician:_____

_____

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PLEASE RETURN THIS FORM TO MEADOWOOD RETIREMENT COMMUNITY
2455 Tamarack Trail, Bloomington, IN 47408
Telephone: 812-336-7060
Fax: 812-333-8917

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Please release the results of this medical information.

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Applicant Signature