Heritage Corner
Health Care Campus

1069 Klotz Rd.- Bowling Green, OH 43402
nursing phone (419)-728-0280 / fax (419)-353-5219

MEDICAL STATEMENT – Initial Health Assessment

Please have your physician complete this form as soon as possible.

To The Physician: Following is a medical history and physical examination form to be completed for a person entering Heritage Inn Assisted Living.or the Heritage Nursing Suites The Heritage provides living accomodations, scheduled personal assistance, medication observation/ reminders, and emergency assistance in obtaining medical services. We have a registered nurse on staff to monitor each resident's health status and to arrange medical services as needed. The Heritage Medical Director oversees the quality of medical services provided by the facility and is on call in the event of a medical emergency or to consult with us regarding a resident's medical condition.

NAME OF CLIENT:_____ **DOB:**_____

SEX:_____**Male** _____**Female** **PHYSICIAN:**_____

MEDICAL HISTORY:

1) Allergies_____
2) Anemia_____
3) Arthritis_____
4) Cancer_____
5) Diabetes_____
6) Hemophilia_____
7) Epilepsy_____
8) Emphysema_____
9) Heart disease_____
10) Kidney disease_____
11) Mental Illness_____
12) Parkinson's_____
13) Pneumonia_____
14) Tuberculosis_____
15) Other_____

DIAGNOSIS: (Medical, Psychiatric or Psychological)

Primary:_____

Secondary:_____

	Yes	No	
Does this person need skilled nursing care?	( )	( )	*If yes, please describe* _____

Does this person need personal care assistance in:

	Yes	No	
Walking	( )	( )	
Bathing	( )	( )	
Dressing	( )	( )	
Eating	( )	( )	(all meals provided)
Getting in/out of bed	( )	( )	
Supervision with ADL's	( )	( )	*If yes, please describe* _____

Use of adaptive devices? _____

(OVER)

PLEASE LIST ALL MEDICATIONS PRESENTLY BEING TAKEN:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ABLE TO SELF-ADMINISTER MEDICATIONS? _____**YES** _____**NO**

If not, what assistance is needed?

_____**VERBAL CUEING BY STAFF (OPEN/REMOVE/APPLY)**

_____**ADMINISTERED BY NURSE**

PHYSICAL EXAM:

1) **EYES**_____ **HEIGHT**_____
   WEIGHT_____
2) **EARS**_____
3) **NOSE**_____
4) **THROAT**_____ **MANTOUX SKIN TEST:**
5) **RESPIRATORY**_____
6) **MUSCULO-SKELETAL**_____ ***1st Step*** **Date Given**_____ **By**_____
7) **CARDIO-VASCULAR**_____ **Results**_____ **Date**_____ **By**_____
8) **GASTRO-INTESTINAL**_____ ***2nd Step*** **Date Given**_____ **By**_____
9) **GENITO-URINARY**_____ **Results**_____ **Date**_____ **By**_____
10) **REPRODUCTIVE**_____
11) **NERVOUS**_____ **Chest X-Ray**_____ **Date Completed**_____
12) **OTHER**_____

Diet_____**Any restrictions or food allergies**_____

Does this person have any mobility impairment or restrictions against physical activity?_____

_____

May this person participate in a structured exercise program?_____

PHYSICIAN'S SIGNATURE_____ **DATE**_____

I hereby authorize information regarding my physical condition to be given to the director of The Heritage.

SIGNATURE OF CLIENT_____ **DATE**_____