

ST. JOHN NEUMANN
MEDICAL EVALUATION
10400 ROOSEVELT BOULEVARD
PHILADELPHIA, PA 19116-3999

MEDICAL FORM

Name _____ Birth Date _____ Age _____ Sex _____

For the purpose of determining my need for St. John Neumann Nursing Home, I authorize the release of any medical information by the physician to the St. John Neumann Nursing Home.

Date _____ Signed _____
Patient or Person Acting for Patient

Chief Complaint and Brief HPI: _____

Does patient know his/his diagnosis? _____ Yes _____ No

History: Illness _____ Date _____

Surgery _____ Date _____

Accidents _____ Date _____

Allergies _____ Date _____

Drug Sensitivity _____

Habits: Alcohol _____ Drugs _____ Smoking _____

Family History: _____

Review of Systems

General: Wt. Loss _____ Wt. Gain _____ Fatigue _____ Fever-Chills _____

Ears: Hearing _____ Tinnitus _____ Vertigo _____

Eyes: Vision _____ Lacrimation _____ Pain _____ Glasses _____

Nose: Discharge _____ Obstruction _____ Epistaxis _____

Throat: Dysphagia _____ Hoarseness _____ Bleeding Gums _____

Respiratory: Cough _____ Expectoration _____ Wheezing _____

Dyspnea _____ Cyanosis _____ Hemoptysis _____ Hoarseness _____

CV: Chest Pain _____ Palpitations _____ Edema _____ Syncope _____ Claudication _____

Rev.10/03

GI: Appetite _____ Nausea _____ Vomiting _____ Abdominal Pain _____

Constipation _____ Diarrhea _____ Jaundice _____ Hemorrhoids _____

GU: Frequency _____ Nocturia _____ Dysuria _____ Hematuria _____ Incontinence _____

Hesitancy _____ Retention _____

GYN: Vaginal Discharge _____ Vaginal Bleeding _____ Menses _____ Menopause _____

Neurologic: Pain _____ Weakness _____ Paralysis _____ Seizures _____

Syncope _____ Tremors _____

Musculoskeletal: Pain _____ Weakness _____ Deformity _____ Limitation of Motion _____

Skin: Itching _____ Dryness _____ Burning _____ Urticaria _____

Decubitus: ___Yes ___No Location _____ Extremities _____ Hip _____ Buttock _____ Other _____

Self Care Status: I= Independent, N=Needs Assistance, U=Unable, C=Chair Ridden, B= Bedridd

Ambulation _____ Feeding _____ Bathing _____ Dressing _____

Bladder Control: Continent _____ Occasional Loss of Control _____ Incontinent _____

Bowel Control: Continent _____ Occasional Loss of Control _____ Incontinent _____

Patient Uses: Appliance _____ Catheter _____ Colostomy _____ Prosthesis _____

Cane _____ Walker _____ Wheelchair _____

Communication Ability: Can Speak _____ Can Write _____ Understands Writing _____

Understands Speaking _____ Understands Gestures _____

Behavior: Noisy _____ Belligerent _____ Suspicious _____ Withdrawn _____

Cooperative _____ Uncooperative _____

Mental Status: Alert _____ Forgetful _____ Confused _____ Depressed _____

Cheerful _____ Agitated _____ Anxious _____

Diet: Regular _____ Special _____ Specify Type if Special Diet _____

Resident is capable of administering his/her own medications: Self _____ Under Supervision _____ No _____

Comments: _____

ST. JOHN NEUMANN
PHYSICAL EXAM

Name _____ Age _____ Date _____

Ht. _____ Wt. _____ BP _____ Pulse _____ RR _____ Temp. _____

General appearance-

Skin _____

Lymphatics- Cervical _____ Axillary _____ Inguinal _____ Other _____

Head- Scalp _____ Skull _____

Eyes _____ Fundoscopy _____

Ears _____

Nose _____

Throat _____

Neck: Thyroid _____ Traches _____ Mass (es) _____ Venous Destention _____

Chest: Shape _____ Resp. _____ Breasts _____

Lungs _____

Heart: Rate _____ Rhythm _____ Size _____ Sounds _____

Murmurs _____

Abdomen: Masses _____ Tenderness _____ Rigidity _____ Scars _____ Liver _____

Kidney _____ Spleen _____ Hernia _____ C.V. Tenderness _____

Genitalia _____

Rectal _____

Pelvic _____

Musculoskeletal _____

Neurologic: _____

Diagnoses: _____

Copies of Lab work sent _____ Yes _____ No _____ CBC _____ UA _____ CXR

Prognosis: _____ Stable _____ Improving _____ Deteriorating
_____ Other (Specify)

Rehabilitation Potential: _____ Good _____ Limited _____ Poor

Immunizations Received:

Flu _____ Yes _____ No Date Given: _____

Pneumovax _____ Yes _____ No Date Given: _____

Tetanus _____ Yes _____ No Date Given: _____

Physician

Orders/Recommendations: _____

Medications: _____

Patient Self Determination/Acknowledgements:

To your knowledge, does your patient have an Advance Directive? _____ Yes _____ No

Can your patient make decisions regarding his/her health and welfare? _____ Yes _____ No

I certify that this patient's medical condition and related needs are essentially as indicated above and that care in an adult day care would be beneficial.

I certify that based on my evaluation there is no evidence of active T.B. or any other communicable disease.

Physician's Signature _____ Date _____

Address _____ Phone # _____