FAR NORTHERN REGIONAL CENTER
MEDICAL HISTORY / PHYSICAL EXAM

Name:

DOB: UCI:

SECTION I

Living Situation:

☐ Independent living ☐ Supported living ☐ Community Care Home ☐ Intermediate Care Facility

Name of Living Facility (if applicable):

Primary Care Physician:

Dentist:

Please list any other doctors, including specialists, regularly seen by the patient

1.
2.
3.
4.

Current Medication: Name, dosage, times taken (include medications taken "as needed" and any over the counter medications)

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Drug Allergies: (List the reaction to each medication, if known)

1.
2.
3.
4.

☐Ambulatory ☐ Non-Ambulatory Per Title 22, Section 80069

Adaptive equipment used:

1. 2.
3. 4.

RETURN COMPLETED FORM TO FNRC NURSE CONSULTANT

SECTION II (TO BE COMPLETED BY MEDICAL PROVIDER)

Current Medical Problems: (Please list any new medical problems which developed over the last year, as well as chronic medical problems. Also list any hospitalizations which occurred over the past year.)

1.
2.
3.
4.
5.
6.
7.
8.

Past Surgical History:

1.
2.
3.
4.

Behavioral Problems: (Please list any behavioral problems such as aggression, depression, obsessive-compulsive behaviors. Please indicate if the patient is seen by a psychiatrist for these problems. Also indicate if the patient has been tried off medications and describe the result of discontinuing medications, if applicable)

Lab Monitoring: (List the most recent labs for drug toxicity monitoring, if applicable)

Preventative Health:

1. Has the patient's cholesterol been measured? ☐ Yes ☐ No
2. Is treatment indicated for hyperlipidemia? ☐ Yes ☐ No
   If so, has treatment been started? ☐ Yes ☐ No
3. Does the patient get yearly flu vaccines? ☐ Yes ☐ No
4. Has Pneumovax been offered if appropriate? ☐ Yes ☐ No
5. For women patients, has a Mammogram been recommended if appropriate? ☐ Yes ☐ No
6. For women patients, has a pelvic exam been attempted in the past? ☐ Yes ☐ No
7. Has the patient been tested for Hepatitis B and/or vaccinated if appropriate? ☐ Yes ☐ No
8. Has the patient ever had a positive TB test? ☐ Yes ☐ No
9. Has the patient been screened for osteoporosis if appropriate? ☐ Yes ☐ No

Habits:

1. Cigarettes? ☐ Yes ☐ No
   If yes, how many packs/day and how long?
2. For smokers, any desire to quit? ☐ Yes ☐ No
3. Alcohol use:
4. Any other drug use, past or present? ☐ Yes ☐ No
5. Exercise?

ROS:

1. Hearing:
   ☐ Hears w/o difficulty ☐ Hearing impaired ☐ Needs hearing acuity/audiometric evaluation
2. Vision:
   ☐ Sees w/o difficulty ☐ Visually impaired ☐ Needs visual acuity/opthamology evaluation

SECTION III
PHYSICAL EXAM

Height: Weight: BP: HR:

General Appearance:

Heent:

Dentition:

Thyroid:

List any significant Lymphadenopathy:

Carotid Bruits:

Breast exam:

Lungs:

Heart:

Abdomen:

GU:

Rectal:

Extremities:

Kyphosis, Scoliosis?

Pulses:

Any skin abnormalities?

Reflexes, motor tone:

Any other significant physical findings?

TB Testing: PPD Placed (list date/time)

Result read (list date/time and result)

Authorization for over the counter medications.

1. Headache	☐ Acetaminophen	Dose:
	☐ Ibuprofen	Dose:
	☐ Other	Dose:
2. Constipation	☐ Milk of Magnesia	Dose:
	☐ Dulcolax Suppository	Dose:
	☐ Senokot	Dose:
	☐ Other	Dose:
3. Allergy Symtoms	☐ Benadryl	Dose:
(Hayfever)	☐ Other	Dose:
4. Indigestion	☐ Tums, Rolaids	Dose:
	☐ Other	Dose:

Impression:

Plan:

Physician Name:

Physician Address:

Telephone Number:

Signature: ____ Date:_______________________