ALPS Adult Day Services

Medical History Form

Dear Physician:

Your patient is applying for enrollment at ALPS Adult Day Services. The information you provide will help ensure that he/she is given appropriate care and services while at our facility. This information will also serve in providing current medical history in the event of an emergency. Information provided on this form is confidential and will only be released with written authorization. Please attach any pertinent test results to this form. Thank you for your assistance.

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name: _____ date of birth: _____ sex: _____

street: _____ city: _____ state: _____ zip: _____

date of last physical exam: _____ weight: _____ blood pressure: _____

date and results of last chest x-ray: _____

date and result of last TB test: _____

date and result of last auditory exam: _____

date and result or last visual exam: _____

Does this person require (circle): *glasses* *hearing aid* *walker* *cane* *wheelchair*

DIAGNOSIS:

primary: _____

secondary: _____

ALLERGIES:

food: _____

medication: _____

other: _____

PHYSICIAN'S ORDERS:

medications: _____

_____

dietary restrictions: _____

physical limitations: _____

recommendations/comments: _____

_____

I have reviewed the health history of this person and find him/her able to participate at ALPS.

Physician signature: _____ date: _____