

THIS HEALTH QUESTIONNAIRE MUST BE COMPLETED BY A FLORIDA LICENSED PHYSICIAN WITHIN FORTY-FIVE (45) DAYS PRIOR TO ENROLLMENT

Date \_\_\_\_\_

Name of patient \_\_\_\_\_ SS# \_\_\_\_\_

Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ B/P \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Mental Condition: \_\_\_\_\_

Physical Condition: \_\_\_\_\_

Past medical, surgical, psychiatric history: \_\_\_\_\_

**IS THIS PATIENT FREE OF DISEASE IN A COMMUNICABLE FORM?**

**(INCLUDING TUBERCULOSIS)? YES \_\_\_\_\_ NO \_\_\_\_\_**

**WE NEED TO KNOW THE "METHOD OF DETERMINATION"**

**i.e. ppd test, chest x-ray or physical exam.... AND THE DATE IT WAS DONE.**

(Please circle "method used")

Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

Speech: \_\_\_\_\_ Ambulation: \_\_\_\_\_

Continenence: \_\_\_\_\_ Bowel: \_\_\_\_\_ Bladder: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

Diet: \_\_\_\_\_ we offer a low fat, no added salt, concentrated sweets diet, which meets the dietary guideline for our clients. Will this be satisfactory for your patient?

Yes \_\_\_\_\_ No \_\_\_\_\_ (explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rehab potential: Good \_\_\_\_\_ fair \_\_\_\_\_ Poor \_\_\_\_\_

Physical Activity Limitations: \_\_\_\_\_

Is your patient permitted to participate in fitness classes designed for frail elderly? Yes/no

Describe other problems that may impact on patient's ability to participate in our program:

\_\_\_\_\_  
\_\_\_\_\_

List each medication prescribed below:

Medication	Dosage/Route	Frequency
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Self administer \_\_\_\_\_ Remind \_\_\_\_\_ Administer \_\_\_\_\_

May Tylenol (or genetic) be given at the discretion of the Centre Nurse on a PRN basis?

YES \_\_\_\_\_ NO \_\_\_\_\_

Recommended frequency of physician visits: \_\_\_\_\_

\_\_\_\_\_  
Print Physician Name

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Address

\_\_\_\_\_  
Physician's Signature/ Date

\_\_\_\_\_  
Preferred Hospital

PLEASE ASSIST YOUR PATIENT IN THIS APPLICATION PROCESS BY COMPLETING THIS HEALTH QUESTIONNAIRE AS PROMPTLY AS POSSIBLE, THANK YOU

We may require periodic updates regarding conditions and treatment of this client as we "SHARE IN CARE"

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