

PATIENT HISTORY AND PHYSICAL for ADULT DAY HEALTH CARE

Alzheimer's Family Services Center • 9451 Indianapolis Avenue, Huntington Beach, CA 92647
(714) 593-9630 Tel • (714) 593-9632 Fax • www.AFSCenter.org

Name: _____ M F DOB: _____ Date of Exam: _____

DIAGNOSES / CONDITIONS reflecting the patient's current health status or **attach electronic health record (EHR):**

Neuro/ Cognitive <input type="checkbox"/> None <input type="checkbox"/> Seizures <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Dementia <input type="checkbox"/> CVA <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Parkinson's <input type="checkbox"/> Neuropathy <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Other:	Cardiovascular <input type="checkbox"/> None <input type="checkbox"/> Arrhythmia <input type="checkbox"/> CAD <input type="checkbox"/> PVD <input type="checkbox"/> Angina <input type="checkbox"/> CHF <input type="checkbox"/> HTN <input type="checkbox"/> Other:
Endocrine/Metabolic <input type="checkbox"/> None <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Non-IDDM <input type="checkbox"/> IDDM <input type="checkbox"/> Neuropathy <input type="checkbox"/> Retinopathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Anemia <input type="checkbox"/> Other:	Musculoskeletal <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Chronic Back Pain <input type="checkbox"/> Other:
Pulmonary/Respiratory <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Other:	Gastrointestinal / Genitourinary <input type="checkbox"/> None <input type="checkbox"/> GERD <input type="checkbox"/> UTI <input type="checkbox"/> PUD <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Other:
Behavioral Health <input type="checkbox"/> None <input type="checkbox"/> Anxiety <input type="checkbox"/> Bi Polar <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	Other Conditions <input type="checkbox"/> None <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Insomnia <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Skin Breakdown <input type="checkbox"/> Other:

PHYSICAL EXAMINATION (Complete or attach EHR)

WNL	Comments	WNL	Comments
<input type="checkbox"/>	HEENT	<input type="checkbox"/>	Gastrointestinal
<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	Genitourinary
<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	Breast / Chest	<input type="checkbox"/>	Integumentary
<input type="checkbox"/>	Neurological	<input type="checkbox"/>	Other:
Significant Physical Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No			

MEDICATION PROFILE (Complete or Attach EHR)

Medication	Dosage	Route	Freq	Medication	Dosage	Route	Freq
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Temp: _____ Pulse _____ Resp Rate _____ BP _____ Height _____ Weight _____
TB SCREENING as Required by Law (Within previous 12 months)
<input type="checkbox"/> PPD Date: _____ Result: _____ OR CXR Date: _____ Result: _____

