APPLICANT'S MEDICAL HISTORY AND PHYSICAL EXAMINATION

Applicant: Please complete the first page and give to your doctor to fill out the rest of this form.

Name of applicant _____

Address _____ Phone (____)_____

City _____ State _____ Zip _____

Date of birth: Month _____ Day _____ Year _____ Age _____

Name of physician (please print): _____

Address _____

_____

Phone (____)_____ FAX No. (____)_____

To any physician, hospital, or clinic:

I HEREBY AUTHORIZE YOU TO GIVE VILLA MARIN HOMEOWNERS' ASSOCIATION ANY INFORMATION THEY REQUEST WITH REFERENCE TO MY MEDICAL HISTORY, OR ADVICE, OR HOSPITALIZATION. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Applicant Date

_____

INSTRUCTIONS TO THE EXAMINING PHYSICIAN

1. Please return the Medical History and Physician Examination Report to the Villa Marin Homeowners' Association in the enclosed envelope. Consideration of your patient's admission cannot continue without this completed form.

2. The physical examination should have been within the last **three (3) months**.

3. Inform your patient that you will mail this report directly to us.

4. Any material misrepresentation or omissions may result in rejection or termination of residence and health care agreements.

5. Additional tests may be required based on the patient's medical history.

THIS IS A RETIREMENT COMMUNITY, NOT A NURSING HOME. THE HEALTH FACILITIES ARE FOR RESIDENTS WHO BECOME ILL OR INFIRM. NEW RESIDENTS ENTERING VILLA MARIN SHOULD NOT PRESENT AN UNACCEPTABLE RISK OF OVER UTILIZATION OF THE PERSONAL CARE OR SKILLED NURSING FACILITIES. THIS EXAMINATION WILL PROVIDE A DETAILED HISTORY THAT WILL ENABLE OUR MEDICAL DIRECTOR AND ADMISSIONS COMMITTEE TO ASCERTAIN THE ELIGIBILITY OF THE APPLICANT. PLEASE KEEP THIS IN MIND AS YOU FILL OUT THE APPLICANT'S HEALTH HISTORY.

I. **MEDICAL HISTORY** (Please print)

a. Family history _____

_____

_____

b. Significant illnesses, including psychiatric illness or mental confusion

_____

_____

_____

c. Significant hospitalizations _____

_____

_____

_____

d. Significant surgeries (include date and surgeon's name) _____

_____

_____

_____

e. List any existing symptoms _____

_____

_____

f. Has there been evidence of substance abuse? Explain. _____

_____

_____

_____

g. Any additional information from your records that you consider an important part of the applicant's medical history would be helpful. _____

_____

_____

_____

II. PHYSICAL EXAMINATION

1. Weight _____ Height _____ Blood Pressure _____ Pulse _____

2. Does the applicant's physical examination reveal abnormalities in any of the following? If yes, give details below:

Head (eyes, ears, nose, throat) _____

_____

Chest (include pulmonary and breast exam) _____

_____

Cardio-vascular _____

_____

Abdominal _____

_____

Genito-urinary (include rectal exam) _____

_____

Skin _____

_____

Bones and joints _____

_____

Neuromuscular _____

_____

Mentation (include results of mental status exam, if done) _____

_____

_____

List of current diagnoses and medications, including dosage _____

_____

_____

_____

EVALUATION

Regarding the questions below, if a descriptive phrase will convey more useful information, we would appreciate the phrase.

a. Is he/she fully able to live independently? _____

b. Is he/she able to care for self in case of emergency, i.e. understand instructions and evacuate the premises without assistance? _____

_____

c. Are you aware of any condition of this applicant that might require attendant or skilled nursing care?

_____

_____

d. Are you aware of any condition of this applicant that might impair the health or comfort of other residents?

_____

_____

e. Are you aware of any impairment of vision or eye disease? If yes, give prognosis and treatment.

_____

_____

f. Is there now, or anticipated in the near future, a need for the use of any devices to assist in mobility?

_____

_____

g. Date last seen by you and total number of visits in the last 12 months _____

The following lab tests (**within one year**) must accompany this report:

a. Complete blood count Date _____
b. Electrocardiogram printout Date _____
c. Complete urinalysis Date _____
d. Written evaluation of chest X-ray Date _____
e. Comprehensive metabolic panel Date _____
f. Stool hemocult Date _____
g. *Pap smear, Mammogram (for women), PSA blood test (for men) – may be requested by the Villa Marin Medical Director on a case by case basis.*

Signature of Physician _____

Specialty _____

Address _____

Telephone _____

Please print this form, sign above, then mail or fax to Villa Marin.

Print Form