Department of Health and Social Services
Division of Alaska Pioneer Homes
History and Physical Report

P.O. Box 110690
Juneau, AK 99811-0690
Toll Free: 888.355.3117
Main: 907.465.4416
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Last Name	First Name	Middle Initial	Telephone Number

Mailing	City	State	Zip	Date of Exam

DOB:	Age	Height	Weight

Medical History: _____

_____

_____

Surgical Hisory: _____

_____

_____

Family History: _____

Social History: _____

Alcohol Use: ☐ Yes ☐ No

Tobacco Use ☐ Yes ☐ No

Other Drugs ☐ Yes ☐ No

Further Information: _____

_____

_____

Physical Examination

Blood Pressure	Temperature	Pulse	Respiration	O2 Stats

A. General appearance, nutrition, debility, hygiene etc: _____

B. Head and Neck _____

C. Nose & Throat _____

D. Dental _____

E. Lungs _____

F. Heart

Vessels: _____

Pulses: _____

G. Abdomen

liver: _____

Rectum: _____

Hernias: _____

History & Physical Examination Report

Applicant's Last Name	First Name	M.I.	Date of Exam
_____	_____	____	_____

H. Male Genitourinary

Genitalia: _____

Prostate: _____

I. Female Pelvic: _____

J. Breast: _____

K. Lymph: _____

L. Endocrine: _____

M. Musculoskeletal: _____

Back: _____

Extremities: _____

N. Skin:

O. Psychiatric:

Orientation: ☐ Clear ☐ Occasionally Disoriented ☐ Disoriented

Mood: _____

Intellect: _____

Short-Term Memory: _____

Cooperation: _____

P. Behavior:

☐ Appropriate ☐ Inappropriate, Aggressive ☐ Inappropriate, Assaultive

☐ Inappropriate, Passive ☐ Wandering - Requires Wandering Safeguards

☐ Inappropriate, suicidal, or otherwise dangerous to self or others

Describe: (Please attach additional information if needed)_____

Q. Neurological

Cranial Nerves: _____

Motor Reflexes: _____

Sensory: _____

Coordination: _____

Vision: _____

Hearing: _____

Additional Information:

History & Physical Examination Report

Applicant's Last Name	First Name	M.I.	Date of Exam
_____	_____	_____	_____

Assessment of Capabilities for Activities of Daily Living

Daily Living

Type	Frequency of Assistance				Extent of Assistance		
	Independent	Occasional	Often	Always	Min	Mod	Max
Bathing							
Dressing							
Grooming							
Oral Hygiene							
Toileting							
Eating							
Ambulation							
In/Out of Bed							
Taking Medications							
Walk up & down stairs							

Uses: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other_____

Activity restrictions?	☐ Yes	☐ No
Dysphagia / Swallowing Difficulties?	☐ Yes	☐ No
Is applicant in full control of bladder?	☐ Yes	☐ No
Is applicant in full control of bowels?	☐ Yes	☐ No

Further information:

_____

_____

_____

Diet

Food Allergies: (Please provide reaction to each food allergy)_____

_____

☐ Regular ☐ Soft ☐ Low Cal ☐ Salt Restricted

☐ Fluid thickened: consistency: _____

☐ Other: _____

Special Instructions: _____

Tuberculosis Status: (Note: This section must be completed <u>before</u> admission)

Date of Last PPD:_____ Results of Last PPD:_____ ____mm

If history of positive PPD, please note past PPD & treatment:

CXR: _____

Medication Tx: _____

Immunizations

Immunizations: (Date of Administration)

Flu Vaccine _____ Pneumovax_____

Diptheria/Tetanus _____ Has applicant received complete Dip/Tet series? _____

Hepatitis A _____ Hepatitis B _____

Zostavax _____

History & Physical Examination Report

Applicant's Last Name	First Name	M.I.	Date of Exam

Drug Allergies

Please provide reaction to each allergy: _____

_____

_____

Medications

Medication	Dosage	Route	Frequency	Diagnosis	ICD10 Code

(Please attach additional information as needed)

Diagnoses

Primary Diagnosis:	ICD10 Code	Onset date
Secondary Diagnoses:	ICD10 Code	Onset date

(Please attach additional information as needed)

Lab Work

Lab work pertinent to Current Diagnoses: _____

_____

Prognosis

_____

_____

I certify I examined _____ on _____

_____ _____

Physician's Signature National Provider Identifier #

_____ _____

Physician's Typed or Printed Name Street Address

_____ _____ _____ _____

Telephone City State Zip Code