THE MANOR
49 WEST GENESEE STREET
SKANEATELES, NEW YORK 13152

MEDICAL RECORD

THIS FORM MUST BE COMPLETED BY A PHYSICIAN AND RETURNED WITH APPLICATION

NAME:_____ DOB: _____/_____/_____

DATE OF EXAMINATION:_____/_____/_____

ALLERGIES : Food:_____

Other:_____

SERIOUS ILLNESS:_____

SURGICAL HISTORY:_____

RECENT HOSPITALIZATION:_____

IN THE PAST FIVE YEARS HAS THE APPLICANT SUFFERED FROM ANY ILLNESS IMPAIRING THEM:

PHYSICALLY ? Y / N EXPLAIN_____

COGNITIVELY ? Y / N EXPLAIN_____

PSYCHOSOCIALLY ? Y / N EXPLAIN_____

CURRENT MEDICATIONS:_____

PLEASE CHECK IF APPLICANT HAS A PAST HISTORY OF THE FOLLOWING AND EXPLAIN BELOW:

DIABETES_____HEART DISEASE_____ASTHMA/COPD_____ HTN_____

DERMATOLOGIC D/O _____BOWEL OR BLADDER D/O _____IMPAIRED MEMORY _____

SEIZURES_____

EXPLAIN IF NECESSARY:_____

PHYSICAL EXAMINATION

HEIGHT:_____WEIGHT:_____BLOOD PRESSURE:_____HEARING:_____

IS VISION IMPAIRED? _____TO WHAT DEGREE? _____

HEART:_____ RESP: _____

COR:_____ MUS/SKEL: _____

NEURO: _____ AMBULATION: _____

PPD:_____ DATE:_____/_____/_____ FLU SHOT? Y / N PNEUMONIA SHOT? Y / N

CXR IF POSITIVE: _____

IS APPLICANT FREE FROM INFECTIOUS DISEASE? Y / N

THE MANOR DOES NOT PROVIDE NURSING CARE OR SPECIAL DIETS. ARE THERE ANY HEALTH ISSUES THAT WOULD PREVENT THIS APPLICANT FROM CARING FOR THEMSELVES, ATTENDING MEALS IN THE DINING ROOM OR OTHERWISE FUNCTIONING IN THE MANOR ENVIRONMENT?

_____

_____

PHYSICIAN'S SIGNATURE_____DATE ____/_____/_____