MEDICAL RECORD

THE MANOR
49 WEST GENESEE ST
SKANEATELES, NEW YORK 13152

This form must be completed by a physician and returned with the application.

Name: _____ DOB: _____/_____/_____

Date of Examination: _____/_____/_____

Serious Illness: _____

Surgical History: _____

Recent Hospitalizations: _____

Fallen with the past year: _____

In the past 5 years has the applicant suffered from any illness impairing them:

Physically? _____N _____Y Explain_____

Cognitively? _____ N _____Y Explain _____

Psychosocially? ____N _____Y Explain_____

Current Medications: _____

Is the resident on any anticoagulation medication? _____N _____Y List _____

ALLERGIES:

Food: _____

Other: _____

Please check if the applicant has a history of the following:

Diabetes	_____N _____Y	Cancer	_____N _____Y
Heart Disease	_____N _____Y	Stroke/TIA	_____N _____Y
Asthma/COPD	_____N _____Y	Kidney Disease	_____N _____Y
HTN	_____N _____Y	Hearing/Sight Problems	_____N _____Y
Dermatologic D/O	_____N_____Y	Glasses	_____N _____Y
Bowel or Bladder D/O	_____N_____Y	Hearing Aid	_____N _____Y
Impaired Memory	_____N_____Y	Dental Appliance	_____N _____Y
Seizures	_____N_____Y	Cane/Walker	_____N _____Y

Explain if necessary

_____

_____

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure_____ Hearing_____

Is vision impaired? ____N_____Y

Please explain_____

HEENT _____

Heart _____

Respiratory _____

COR_____

MUS/SKEL _____

Neurological_____

Ambulation_____

PPD _____ Date _____

CXR if Positive_____

Fully vaccinated against Covid including booster? _____N_____Y

Flu Vaccine _____N _____Y

Pneumonia Vaccine _____ N _____Y

Tetanus _____ N _____Y

Is applicant free from infectious disease? _____ N _____Y

The Manor is an independent living facility. The Manor does not provide nursing care or special diets. To the best of your knowledge are there any health issues that would prevent this applicant from caring for themselves, attending meals in the dining room and living independently in The Manor with other senior residents?

_____N _____Y

Physicians' Signature_____

Date_____