ARMED FORCES RETIREMENT HOME
MEDICAL EXAMINATION FORM

Name				**Age**	
Address				**DOB**	
City		**State**		**Zip**	
Phone				**M** ◯ **F** ◯	
LIVING ARRANGEMENTS ◯ **Alone** ◯ **With Family** ◯ **Other** _____					

PAST MEDICAL HISTORY (TO BE COMPLETED BY PROVIDER ONLY) CIRCLE: YES (Y) OR NO (N)

Y	**N**	**ANTICOAGULATION THERAPY**	**Y**	**N**	**STROKE**	**Y**	**N**	**PRESCRIPTION DRUG ABUSE WITHIN 1 YEAR**
Y	**N**	**CARDIOVASCUALAR DISEASE /MI**	**Y**	**N**	**HOSPITALIZATIONS (MEDICAL)**	**Y**	**N**	**ILLEGAL DRUG ABUSE WITHIN 1 YEAR**
Y	**N**	**CONGESTIVE HEART FAILURE**	**Y**	**N**	**HEAD INJURIES**	**Y**	**N**	**CURRENT ALCOHOL ABUSE WITHIN 1 YEAR**
Y	**N**	**COPD/ASTHMA**	**Y**	**N**	**SEIZURES**	**Y**	**N**	**AMPUTATIONS**
Y	**N**	**OXYGEN THERAPY**	**Y**	**N**	**MENTAL HEALTH ISSUES**	**Y**	**N**	**VISION LOSS**
Y	**N**	**GASTROINTESTINAL DISORDERS**	**Y**	**N**	**HOSPITALIZATIONS (PSYCHIATRIC)**	**Y**	**N**	**CHRONIC PAIN**
Y	**N**	**COLOSTOMY**	**Y**	**N**	**DEPRESSION**	**Y**	**N**	**DEMENTIA**
Y	**N**	**DIABETES**	**Y**	**N**	**MEMORY LOSS**	**Y**	**N**	**PARKINSON'S DISEASE**
Y	**N**	**IMMUNE DISORDERS**	**Y**	**N**	**PSYCHOSIS**	**Y**	**N**	**OTHER:**
Y	**N**	**CANCER**	**Y**	**N**	**PTSD**	**Y**	**N**	**OTHER:**

LIST ALL ALLERGIES, INCLUDING MEDICATIONS, FOODS, LATEX, ETC.

1.	**2.**	**3.**	**4.**
5.	**6.**	**7.**	**8.**

LIST ALL CURRENT MEDICATIONS

1.	**2.**	**3.**
4.	**5.**	**6.**
7.	**8.**	**9.**
10.	**11.**	**12.**
13.	**14.**	**15.**

MEDICATION RECONCILIATION (I CONFIRM THAT THE MEDICATIONS AS ANNOTATED ABOVE ARE ACCURATE AND CURRENT)

_____ PRIMARY CARE PROVI DER INITIALS

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MEDICAL EXAMINATION (TO BE COMPLETED BY PROVIDER OR MEDICAL PROFESSIONAL ONLY)

VITALS

BLOOD PRESSURE		**TEMPERATURE**	
PULSE		**HEIGHT**	
RESP. RATE		**WEIGHT**	

PHYSICAL EXAMINATION (TO BE COMPLETED BY PROVIDER OR MEDICAL PROFESSIONAL ONLY)

PLEASE CIRCLE:	**NORMAL**		**ABNORMAL**	**IF ABNORMAL, EXPLAIN SYMPTONS/SIGNS**
HEENT (HEAD, EYES, EARS, NOSE, THROAT)	**Y**		**N**	
NECK	**Y**		**N**	
CARDIOVASCULAR	**Y**		**N**	
LUNGS	**Y**		**N**	
THYROID	**Y**		**N**	
ABDOMEN	**Y**		**N**	
LYMPHATIC	**Y**		**N**	
NEUROLOGICAL	**Y**		**N**	
EXTREMITIES	**Y**		**N**	
SKIN	**Y**		**N**	

INDEPENDENT SELF CARE (TO BE COMPLETED BY PROVIDER OR MEDICAL PROFESSIONAL ONLY)

PLEASE CIRCLE:	**YES or**		**NO**	**IF NO, PLEASE PROVIDE AN EXPLANATION**
AMBULATION	**Y**		**N**	
BATHING/HYGIENE	**Y**		**N**	
DRESSING	**Y**		**N**	
EATING	**Y**		**N**	
MEDICATION	**Y**		**N**	

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ACTIVITIES OF DAILY LIVING (FOR PROVIDER TO CHECK ALL THAT APPLY)

☐ VERBAL	☐ IMPAIRED VISION (LOW VISION)
☐ NON-VERBAL	☐ IMPAIRED HEARING (HEARING AID)
☐ BOWEL INCONTINENCE	☐ BLADDER INCONTINENCE
☐ DENTURES	☐ URINARY CATHETER

LEVEL OF CARE (PROVIDER PLEASE CHECK APPROPRIATE BOX AND INITIAL)

☐ **INDEPENDENT LIVING**

☐ **ASSISTED CARE**

INCLUDES SOME AID IN ACTIVITIES OF DAILY LIVING, DIVERSIONARY ACTIVITIES, PROTECTION FROM HAZARDS AND/OR MINIMAL ASSISTANCE

☐ **SKILLED CARE**

INCLUDES PROFESSIONAL NURSING CARE AND ASSESSMENT ON A DAILY BASIS DUE TO A SERIOUS CONDITION, WHICH IS UNSTABLE, OR A REHABILITATIVE, THERAPEUTIC REGIME REQUIRING A PROFESSIONAL STAFF

_____ PRIMARY CARE PROVIDER INITIALS

TUBERCULOSIS SCREENING TEST

TST SCREENING TEST (CIRCLE RESULT)	**MM INDURATION**	**NEG**	**POS**
DATE OF TEST RESULTS	**MONTH**	**DAY**	**YEAR**
IF POSITIVE, LIST CONVERSION DATE	**MONTH**	**DAY**	**YEAR**
CHEST X-RAY DATE	**MONTH**	**DAY**	**YEAR**
CHEST X-RAY RESULTS AND FINDINGS			
INTEFERON GOLD TEST			
***MEDICAL PROFESSIONAL SIGNATURE**			
TODAY'S DATE			

APPLICANT IS REQUIRED TO TAKE A TUBERCULOSIS SCREENING TEST FOR ADMISSION TO AFRH. *Stamps are accepted but the Medical Professional MUST sign with handwritten signature and date or your form will be returned.

EXAMINER PRINTED NAME	
EXAMINER TITLE	
EXAMINER SIGNATURE AND DATE	
OFFICE ADDRESS	
CONTACT NUMBER	

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MENTAL STATUS AND BEHAVIOR (TO BE COMPLETED BY PROVIDER OR MEDICAL PROFESSIONAL ONLY)

	MENTAL STATUS AND BEHAVIOR	Never	Rarely	Sometimes	Frequently	Always	Comments
1	Does the patient show signs of memory loss or forgetfulness?	1	2	3	4	5	
2	Does the patient show signs of depression?	1	2	3	4	5	
3	Does the patient show signs of wandering?	1	2	3	4	5	
4	Does the patient show signs of hostile, aggressive, and or combative behavior?	1	2	3	4	5	
5	Does the patient show signs of confusion?	1	2	3	4	5	
PLEASE CIRCLE: YES or NO							
6	Has the patient been on any psychiatric medications during the last 5 years?	Y			N		
7	Is the patient capable of living in community environments?	Y			N		
8	Is the patient a danger to self?	Y			N		
9	Is the patient a danger to others?	Y			N		
	ORIENTATION						Comments
PLEASE CIRCLE: YES or NO							
1	PERSON	Y			N		
2	PLACE	Y			N		
3	DATE/TIME	Y			N		
4	SITUATION	Y			N		

ARMED FORCES RETIREMENT HOME
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AFRH Applicant information:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Healthcare provider information:

Name: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

I grant my permission to disclose information to the following entity:

Armed Forces Retirement Home	Armed Forces Retirement Home
3700 Capitol Street, NW, Admissions	1800 Beach Drive, Admissions
Washington, DC 20011	Gulfport, MS 39507

Specific information to be disclosed:

□ Medical Records covering the last twelve months

□ Patient history and office notes

□ Billing records

□ Insurance records

□ Drug, Alcohol or Substance Abuse Records

□ Mental Health Records

□ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

Signature of Applicant: _____ Date: _____