St. Francis

HEALTHCARE SYSTEM OF HAWAII
A Legacy of Caring for Hawaii's People

St. Francis Adult Day Center

Health & Physical Form

Personal Information:

Name______________________ Address____

Birth date _____________ Gender _________ Marital Status _____ Ethnicity____________

Primary Physician _____________________ Address _______________________________________

Phone _____________________________ Exchange _______________________________________

Secondary Physician ____________________ Address _____________________________________

Phone______________________________ Exchange _______________________________________

Preferred Hospital ____

Physical/Mental Exam:

Diagnosis: Primary _____________________ Secondary ____________________________________

Major medical problems ____

Psychiatric history ____

Allergies ____________________ Reaction to allergen _____________________________________

Height ___________ Weight ________ Pulse Rate __________ Resp _____ BP _______________

Vision ___________________________ Hearing _______________________________________

Other significant findings ____

Date, number of days, and reason for last hospitalization (if any)

____

____

Diet and Medications:

Diet: Regular _____ Yes _____ No Special Diet Instructions: _____________________________

____

Medications: (Name, dosage, time to be given. Please attach extra sheet if needed.)

1. _____________________________ 2. ___________________________________

3. _____________________________ 4. ___________________________________

5. _____________________________ 6. ___________________________________

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May Aspirin or Tylenol be given? _____ Yes _____ No

Should vital signs be taken? ____________ How often? ______________________________________

Functional Level:

	Independent	Supervised	Assist (how many people?)
Eating	____________	__________	______________
Dress/groom	____________	__________	______________
Bathing	____________	__________	______________
Toileting	____________	__________	______________
Transferring	____________	__________	______________
Walking/mobility	____________	__________	______________

History of wandering behavior? ____

History of falls? _______________ When? _________________ Cause? _____________

Continence: Urine ___ Yes ___ No Bowel ___ Yes ___ No

Physical Aids:

Dentures ___ Eyeglasses ___ Hearing Aid ___

Walker ___ Wheel chair ___ Cane ___

Prosthesis ___ Other ___

Participant may take part in sitting/standing exercises for older adults?

Yes ___ No ___ Comments:

____

____

Social and Environmental:

Primary caregiver ___________________ Relationship: _________________________

Pertinent family medical history: ____

Support person/network: ____

Resides: Alone __________ With Family ____________ Other ___________

Resides in: single family home _______ Apartment ____________________________

Are there stairs for physical barriers? ____

TB Clearance:

(State of Hawaii regulations require the entry Tuberculosis Evaluation be based on the two step Mantoux skin test supplemented by a standard chest x-ray as needed).

PPD Skin Test:

Date Read ______________ Result (circle one): ____Negative _____

Positive Date of Chest X-ray ___________________ Result: _____Negative ____Positive

Participants in Adult Day Care who present a standard chest X-ray after a positive reading on Manitou skin test must be screened for symptoms consistent with pulmonary TB. These symptoms include:

(1) Cough with more than 3 weeks duration *and*

(2) At least one of the following:

a. fever

b. night sweats

c. unintentional weight loss = more than 10% body weight

d. hemoptysis, or

e. malaise/fatigue

I have examined this patient and found him/her to be free of these symptoms of TB. Based on my examination, the patient appears appropriate for attendance at a social model adult day care program.

______________________________ ____________________

Physician's Signature Date