

MEDICAL HISTORY & PHYSICAL EXAM

Name: _____ Date of Birth: _____

Address: _____

B/P: _____ Weight: _____ Height: _____

Allergies: _____

Medical History: _____

Surgical History: _____

Review of Systems:

Cardiovascular: _____

Endocrine: _____

Gastrointestinal: _____

Heent: _____

Integumentary: _____

Musculoskeletal: _____

Neurosensory: _____

Respiratory: _____

Urinary: _____

Vitals: Temp: _____ Pulse: _____ Resp: _____ B/P: _____

Last: Tuberculin Skin Test: _____ Results: _____

Influenza Vaccination: _____ Tetanus: _____

Pneumococcal Vaccination: _____

Diet: _____ Activity Level: _____

Advance Directives: _____ Living Will: _____ DNR: _____

Please list current Medications and Diagnosis for each.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I hereby recertify that she/he requires the following indicated care in accordance with Chapter 135C of the Iowa, 19970 Health Facilities Act.

Nursing Care _____

_____ M. D. Date: _____

Address: _____