

**MEDICAL HISTORY AND ADMISSION EXAMINATION  
MONTANA VETERANS' HOME**

ALL pages of this form need to be completed and signed by your current physician. Please be sure all requested information is supplied, as the Home will not be able to review or admit you until information is received.

<p style="text-align: center; margin: 0;">_____</p> <p style="margin: 0;"><small>LAST NAME</small>                      <small>FIRST NAME</small></p>	ATTENDING PHYSICIAN
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ADMISSION DIAGNOSIS (STATE FULLY)

PAST IMMUNIZATION HISTORY

\*PPD DATE \_\_\_\_\_ CONVERTED: YES  NO  TREATED: YES  NO

*\*PPD will be done no later than 4 weeks prior to admission. If unable to receive skin testing, a certification signed by applicant's physician showing that he/she is free of TB must be received or applicant will not be accepted for admission to the Montana Veterans' Home.*

INFLUENZA VIRUS: YES  DATE: \_\_\_\_\_ NO  PNEUMOVAC: YES  DATE: \_\_\_\_\_ NO

SUMMARY OF PRESENT ILLNESSES

SUMMARY OF PREVIOUS ILLNESSES

IF APPLICANT HAS SEIZURE DISORDER, DESCRIBE FREQUENCY AND NATURE OF SEIZURES

DOES APPLICANT HAVE CARDIOVASCULAR PROBLEMS YES  NO

IF YES, EXPLAIN STAGE \_\_\_\_\_

DOES APPLICANT HAVE A PACEMAKER YES  DATE: \_\_\_\_\_ NO  DATE OF LAST EKG \_\_\_\_\_

DESCRIBE IF DEMENTIA OR MENTAL ILLNESS PRESENT

DOES APPLICANT HAVE A CONTAGIOUS DISEASE IN COMMUNICABLE STAGE? YES  NO

IF YES, EXPLAIN \_\_\_\_\_

HAS APPLICANT EVER HAD AND/OR BEEN TREATED FOR TB? YES  NO

IF YES, EXPLAIN \_\_\_\_\_

HAS APPLICANT EVER HAD AND/OR BEEN TREATED FOR MRSA OR VRE? YES  NO

IF YES, EXPLAIN \_\_\_\_\_

LIST MEDICATIONS PRESENTLY BEING PRESCRIBED FOR APPLICANT		
MEDICATION	DOSAGE	DIAGNOSIS

LIST ANY ALLERGIES

CURRENT DIET – INCLUDE CALORIC REQUIREMENTS AND ANY SPECIFIC RESTRICTIONS

STATE TYPE AND DEGREE OF DISABILITY, IF ANY

PROGNOSIS AND GOALS FOR REHABILITATION

DOES APPLICANT USE ALCOHOL? CURRENTLY: YES  NO  HISTORY OF USE: YES  NO   
IF YES, HOW FREQUENTLY?  WEEKLY  2-3 TIMES/MONTH  INFREQUENTLY  
HAS APPLICANT ATTENDED AN ALCOHOL TREATMENT PROGRAM? YES  NO   
IF YES, AS INPATIENT  OUTPATIENT  DATES(S): \_\_\_\_\_

HAS APPLICANT BEEN DIAGNOSED WITH A MENTAL ILLNESS? YES  DIAGNOSIS: \_\_\_\_\_ NO   
HAS APPLICANT BEEN TREATED FOR A MENTAL ILLNESS? YES  NO   
INPATIENT: YES  DATE(S) \_\_\_\_\_  
OUTPATIENT: YES  DATE(S) \_\_\_\_\_

HAS APPLICANT BEEN DIAGNOSED WITH A MENTAL ILLNESS? YES  DIAGNOSIS: \_\_\_\_\_ NO   
HAS APPLICANT BEEN TREATED FOR A MENTAL ILLNESS? YES  NO   
INPATIENT: YES  DATE(S) \_\_\_\_\_  
OUTPATIENT: YES  DATE(S) \_\_\_\_\_

DOES APPLICANT SMOKE? YES  NO  / CIGARETTES  PIPE  CIGARS

ADDITIONAL MEDICAL INFORMATION

ANY RECOMMENDATIONS, ETC.

<b>FUNCTIONAL CAPABILITIES</b>	<b>ACTIVITIES OF DAILY LIVING ASSESSMENT</b>		<b>FUNCTIONAL CAPABILITIES</b>	<b>ABLE</b>	<b>UNABLE</b>
	<b>ABLE</b>	<b>UNABLE</b>			
Changes own position	<input type="checkbox"/>	<input type="checkbox"/>	Attend to personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>
Can sit by self	<input type="checkbox"/>	<input type="checkbox"/>	Groom self: Face and hands	<input type="checkbox"/>	<input type="checkbox"/>
Able to walk upstairs	<input type="checkbox"/>	<input type="checkbox"/>	Bathe	<input type="checkbox"/>	<input type="checkbox"/>
Able to walk downstairs	<input type="checkbox"/>	<input type="checkbox"/>	Brush teeth	<input type="checkbox"/>	<input type="checkbox"/>
Can bear weight on feet	<input type="checkbox"/>	<input type="checkbox"/>	Comb hair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both			Get in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>
Get into and out of bathtub	<input type="checkbox"/>	<input type="checkbox"/>	Transfer to/from toilet by self	<input type="checkbox"/>	<input type="checkbox"/>
Can make own bed	<input type="checkbox"/>	<input type="checkbox"/>	Feed self	<input type="checkbox"/>	<input type="checkbox"/>
Walk independently	<input type="checkbox"/>	<input type="checkbox"/>	Dress/undress self	<input type="checkbox"/>	<input type="checkbox"/>
Walk with aid of appliances	<input type="checkbox"/>	<input type="checkbox"/>	Toilet self	<input type="checkbox"/>	<input type="checkbox"/>
Identify crutches, cane, walker, etc			Shopping	<input type="checkbox"/>	<input type="checkbox"/>
Get out of chair/wheelchair without help	<input type="checkbox"/>	<input type="checkbox"/>	Money management	<input type="checkbox"/>	<input type="checkbox"/>
Get in chair or wheelchair without help	<input type="checkbox"/>	<input type="checkbox"/>	Self medication	<input type="checkbox"/>	<input type="checkbox"/>
Go through doors independently	<input type="checkbox"/>	<input type="checkbox"/>			

Order for admission:  Yes  No Check one:  Intermediate care  Skilled care  Domiciliary

Physician's signature \_\_\_\_\_

Address: \_\_\_\_\_

Date of examination \_\_\_\_\_