

Arcadia Home Health/Home Care Services
HISTORY AND PHYSICAL FORM
(To be completed by Physician)

I. PERSONAL INFORMATION Date of Exam _____

Name _____ Address _____

Marital Status _____ Birthdate _____ Age _____ Sex _____ Race _____

Physician _____ Address _____
(Please Print) (Street, Suite #, City, Zip)

Telephone _____ Physician's Exchange _____

II. ALLERGIES

III. PERTINENT MEDICAL HISTORY

IV. PERTINENT SURGICAL HISTORY

V. PHYSICAL EXAMINATION

General: Height _____ Weight _____ BP _____ Pulse Rate _____

EENT: _____

Vision _____

Hearing _____

Neck _____

Lungs _____

Heart _____

Back-Skeletal _____

Abdomen _____

Genitalia/Pelvic _____

Rectal _____

Extremities _____

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VI. RECOMMENDED DIET

Regular Special _____ NG Tube Other _____

VII. ACTIVITY

Ambulation Independent Assistance Device(s) _____
 Total Dependence History of Falls _____

Is massage contraindicated? Yes No

VIII. CODE STATUS

IX. PRESENT MEDICATIONS (Name, Dosage, Frequency)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Comments:	

IX. DIAGNOSIS

Primary _____

 Secondary _____

I certify that the client's medical condition is as indicated above.

 Physician's Signature

 Date