

Meadowood Retirement Community  
CONFIDENTIAL HEALTH INFORMATION  
*To be completed by Physician*

Name of Applicant \_\_\_\_\_

(Last) (First) (Middle)  
Date of Examination \_\_\_\_\_ Birth Date \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Current: Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

How long have you cared for this patient? \_\_\_\_\_

Check any of the following conditions which apply to your patient:

_____ Asthma	_____ Diabetes	_____ Emphysema
_____ Cancer	_____ High Blood Pressure	_____ Emotional Problems
_____ Heart Problems	_____ Arthritis	_____ Contagious Diseases
_____ Smoking	_____ Drug/Alcohol Addiction	

Please explain further any conditions that are checked above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please record abnormalities:

Skin _____	Mouth _____
Neck _____	Breasts _____
Lungs _____	Abdomen _____
Heart _____	Extremities _____

History of Serious Illness:

Infections: \_\_\_\_\_ Hypertension: \_\_\_\_\_

Operations: \_\_\_\_\_

Cancer with dates treated: \_\_\_\_\_

Allergies (please be specific) \_\_\_\_\_

\_\_\_\_\_

Current Medications of patient: \_\_\_\_\_

\_\_\_\_\_

Special Diet, if any \_\_\_\_\_

Special Aids \_\_\_\_\_

Please circle appropriate description:

Alert          Well Oriented          Confused          Senile          Severely Senile

Is resident fully able to live independently and to care for self? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please comment on resident's ability to live independently \_\_\_\_\_

\_\_\_\_\_

(over)

Do you detect evidence of a condition that probably will lead to the need for prolonged infirmity care?  
If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

If patient is moving from out-of-town, who will be the local physician? \_\_\_\_\_

Is applicant ambulatory? (with or without aids such as cane or walker?)	_____yes	_____no
Is applicant capable of bathing and dressing without assistance?	_____yes	_____no
Can applicant manage toilet facilities alone?	_____yes	_____no
Can applicant move in and out of bed/chair without assistance?	_____yes	_____no
Does applicant arrange his/her own medical care and prescriptions?	_____yes	_____no
Does applicant comply with medication schedules and any special diets?	_____yes	_____no

On the basis of my physical findings, no disease or condition is present that may impair the health or comfort of other residents at Meadowood Retirement Community. This applicant is \_\_\_\_\_ is not \_\_\_\_\_ able to live alone and maintain a daily schedule without assistance and is ambulatory.

Any additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name and address/phone number of physician: \_\_\_\_\_  
\_\_\_\_\_

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PLEASE RETURN THIS FORM TO MEADOWOOD RETIREMENT COMMUNITY  
2455 Tamarack Trail, Bloomington, IN 47408  
Telephone: 812-336-7060  
Fax: 812-333-8917  
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Please release the results of this medical information.

\_\_\_\_\_  
Applicant Signature