Rae's Playze Adult Day Center
SEEING THROUGH THE EYES OF OTHERS

Medical History Form

Dear Physician:

Your patient is applying for enrollment at RPADC Adult Day Services. The information you provide will help ensure that he/she is given appropriate care and services while at our facility. This information will also serve in providing current medical history in the event of an emergency. Information provided on this form is confidential and will only be released with written authorization. Please attach any pertinent test results to this form. Thank you for your assistance.

Full Name: _____ Date of Birth: _____ Sex: _____
first middle last

Street: _____ City: _____ State: _____ Zip: _____

Date of last physical exam: _____ Weight: _____ Blood Pressure: _____

Date and results of last chest x-ray: _____

Date and result of last TB test: _____

Date and result of last auditory exam: _____

Date and result or last visual exam: _____

Does this person require (check): ☐ *glasses* ☐ *hearing aid* ☐ *walker* ☐ *cane* ☐ *wheelchair*

DIAGNOSIS

Primary: _____

Secondary: _____

Other diseases/conditions: _____

ALLERGIES

Food: _____

Medication: _____

Other: _____

PHYSICIANS' ORDER

Medications: _____

_____

Dietary: ☐ Regular ☐ No Sugar Added ☐ Diverticulosis

Physical activities/restrictions:

_____

_____

_____

_____

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Medical History Form

Participant name:____ Date of Birth:________________

medication:		purpose:	
specific time(s):		dose:	
medication:		purpose:	
specific time(s):		dose:	
medication:		purpose:	
specific time(s):		dose:	
medication:		purpose:	
specific time(s):		dose:	
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specific time(s):		dose:	
medication:		purpose:	
specific time(s):		dose:	
medication:		purpose:	
specific time(s):		dose:	

PRN MEDICATION:

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Is participant ALLOWED to have any of the following medications?

☐ Yes	☐ No	Tylenol 500mg, 1-2 tablets Q4 hrs. by mouth as needed for pain
☐ Yes	☐ No	Ibuprofen 200mg, 1-2 tablets Q6 hrs. by mouth as needed for pain
☐ Yes	☐ No	Loperamide (Imodium) 2mg, 1-2 capsules by mouth initial dose followed by 1 capsule after each loose stool. Limit to 4 capsules daily
☐ Yes	☐ No	Tums 500mg, 2-4 tablets by mouth as needed for antacid and upset stomach. Limit to 15 tablets daily
☐ Yes	☐ No	Polysporin ointment, apply as needed after wound care for minor cuts or scrapes

GENERAL INFORMATION:

☐ Yes	☐ No	Does the person require constant supervision to make sure harm is not done to self, others or property?
☐ Yes	☐ No	Will this person wonder off of not closely attended?
☐ Yes	☐ No	Can this person do light exercise from a sitting position, such as leg lifts arm lifts, etc.?
☐ Yes	☐ No	Do you recommend any special type of activities for this client, such as group social activities, crafts activities, physical exercise, training in self-care?

IF PARTICIPANT NEEDS SEAT BELT IN WHEELCHAIR WHILE ATTENDING DAYCARE/DAY HEALTH PROGRAM, PLEASE INDICATE: ☐ Yes ☐ No

SIGNATURE REQUIRED:

☐ Yes	☐ No	Is a special diet or other special regimen required for this patient? *If yes please attach or decribe.*
☐ Yes	☐ No	Is there a presence/degree of psychological problems

_____ I certify that I have today reviewed the health history and examined this person and find him/her physically able to participate in an adult care activity program.

Signed:_____ Date: _____
M.D., PA or Nurse Practitioner

Address:_____ City: _____State: _____ Zip: _____

Phone:_____Email: _____