MEDICAL EVALUATION

All Spaces Must Be Filled Out

Resident's Name: _____

Facility Name: _____ **Date of Birth:** _____

Present Home Address: _____

MEDICAL REVIEW FINDINGS

Vital Signs: BP:_____**Pulse:**_____ **Resp:**_____ **T:**_____ **Height:** _____**ft** _____

Primary Diagnosis(s) : _____

_____

Secondary Diagnosis(s): _____

_____

Allergies: **None or list Known Allergies:**

Diet: ☐ **Regular** ☐ **No Added Salt** ☐ **No Concentrated Sweets** ☐ **Other:**_____

Immunizations: ☐ **Influenza (Date** _____**)** ☐ **Pneumococcal Vaccine (date**__**)**

TB SCREENING (performed **within 30 days prior to initial admission** unless medically)

☐ **Test is contraindicated** **Test:** ☐**TST1** ☐**TST2** ☐**TB Blood Test(Type)**_____

TST: Date placed_____**Date Read**_____ **mm** _____**TST2: date placed**_____