Homer Senior Citizens, Inc.

3935 Svedlund Street
Homer, Alaska 99603
(907) 235-7655 Fax: (907) 235-3739

MEDICAL HISTORY

MUST BE COMPLETED BY A PHYSICIAN - PLEASE RETURN BY FAX

Name: _____ Sex: M F Date of Birth: _____

Physician Name: _____ Clinic: _____ Phone: _____

Diagnoses/Medical conditions:

☐ Seizures	☐ Cancer	☐ CVA
☐ Glaucoma	☐ Lung Condition	☐ Parkinson's
☐ Cataracts	☐ Diabetes	☐ Multiple Sclerosis
☐ High BP	☐ Anemia	☐ Alzheimer's
☐ Arthritis	☐ TB	☐ Cerebral Palsy
☐ Kidney Disease	☐ Heart	☐ Osteoporosis
☐ Arteriosclerosis	☐ Prostate	☐ Allergies
☐ Incontinent Bowel	☐ Bladder	☐ Dementia

Other: _____

_____

Allergies: _____

Mental Condition – describe: _____

Weight _____
Height _____

DNR Request or Comfort One _____
Please provide copy.

Medications, dosage and time. Include PRN and OTC: (use the back for more space)

_____ _____ _____
_____ _____ _____
_____ _____ _____

TB Test, Chest X-ray or PPD (within the past year): Date Administered _____ Results _____

Diet: ☐ Regular Diet ☐ Modified Diet Explain _____

_____

Physical Limitations: ☐ No ☐ Yes Explain: _____

_____

PRN Orders: _____

_____

Please identify any concerns: _____

_____

I certify that this patient does not have a communicable disease in a transferable stage.

Physician Signature _____ Date _____