



# State of Alaska Pioneers' Home History & Physical Examination Report

Applicant's Last Name	First Name	M.I.	Date of Exam
DOB (mm/dd/yyyy)	Age	Sex	Race
Height		Weight	

**Medical History:**

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**Surgical History:**

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**Family History:**

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**Social History:**

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Alcohol Use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Further information: <hr/> <hr/>
Tobacco Use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other Drugs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

### Physical Examination

Blood Pressure	Temperature	Pulse	Respiration	O2 Sats
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A. General appearance, nutrition, debility, hygiene, etc: \_\_\_\_\_

B. Head and Neck: \_\_\_\_\_

C. Nose and Throat: \_\_\_\_\_

D. Dental: \_\_\_\_\_

E. Lungs: \_\_\_\_\_

F. Heart: \_\_\_\_\_

Vessels: \_\_\_\_\_

Pulses: \_\_\_\_\_

G. Abdomen \_\_\_\_\_

Liver: \_\_\_\_\_

Rectum: \_\_\_\_\_

Hernias: \_\_\_\_\_

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**H. Male Genitourinary**

Genitalia: \_\_\_\_\_

Prostate: \_\_\_\_\_

**I. Female Pelvic:** \_\_\_\_\_

**J. Breast:** \_\_\_\_\_

**K. Lymph:** \_\_\_\_\_

**L. Endocrine:** \_\_\_\_\_

**M. Musculoskeletal:** \_\_\_\_\_

Back: \_\_\_\_\_

Extremities: \_\_\_\_\_

**N. Skin:**

**O. Psychiatric:**

Orientation:     Clear                       Occasionally Disoriented                       Disoriented

Mood: \_\_\_\_\_

Intellect: \_\_\_\_\_

Short-Term Memory: \_\_\_\_\_

Cooperation: \_\_\_\_\_

**P. Behavior:**

Appropriate                       Inappropriate, Aggressive                       Inappropriate, Assaultive

Inappropriate, Passive                       Wandering - Requires Wandering Safeguards

Inappropriate, suicidal, or otherwise dangerous to self or others

Describe: (Please attach additional information if needed) \_\_\_\_\_

**Q. Neurological**

Cranial Nerves: \_\_\_\_\_

Motor Reflexes: \_\_\_\_\_

Sensory: \_\_\_\_\_

Coordination: \_\_\_\_\_

Vision: \_\_\_\_\_

Hearing: \_\_\_\_\_

Additional Information:

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M.I. \_\_\_\_\_

Date of Exam \_\_\_\_\_

Assessment of Capabilities for Activities of Daily Living								
Daily Living	Type	Frequency of Assistance				Extent of Assistance		
		Independent	Occasional	Often	Always	Min	Mod	Max
	Bathing							
	Dressing							
	Grooming							
	Oral Hygiene							
	Toileting							
	Eating							
	Ambulation							
	In/Out of Bed							
	Taking Medications							
	Walk up & down stairs							
Uses: <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other _____								
Activity restrictions?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Further information: _____ _____ _____				
Dysphagia / Swallowing Difficulties?		<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Is applicant in full control of bladder?		<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Is applicant in full control of bowels?		<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Diet	Food Allergies: (Please provide reaction to each food allergy) _____							
	<input type="checkbox"/> Regular <input type="checkbox"/> Soft <input type="checkbox"/> Low Cal <input type="checkbox"/> Salt Restricted							
	<input type="checkbox"/> Fluid thickened: consistency: _____							
	<input type="checkbox"/> Other: _____							
Special Instructions: _____								
Tuberculosis Status: (Note: This section must be completed <u>before</u> admission)								
Date of Last PPD: _____ Results of Last PPD: _____ mm								
If history of positive PPD, please note past PPD & treatment:								
CXR: _____								
Medication Tx: _____								
Immunizations								
Immunizations: (Date of Administration)								
Flu Vaccine _____			Pneumovax _____					
Diphtheria/Tetanus _____			Has applicant received complete Dip/Tet series? _____					
Hepatitis A _____			Hepatitis B _____					
Zostavax _____								

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## Drug Allergies

Please provide reaction to each allergy: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Medications

Medication	Dosage	Route	Frequency	Diagnosis	ICD9 Code

(Please attach additional information as needed)

## Diagnoses

Primary Diagnosis:	ICD9 Code	Onset date
Secondary Diagnoses:	ICD9 Code	Onset date

(Please attach additional information as needed)

## Lab Work

Lab work pertinent to Current Diagnoses: \_\_\_\_\_  
 \_\_\_\_\_

## Prognosis

\_\_\_\_\_

I certify I examined \_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_  
 Physician's Signature National Provider Identifier #

\_\_\_\_\_  
 Physician's Typed or Printed Name Street Address

\_\_\_\_\_  
 Telephone City State Zip Code