Anne Grady SERVICES

MEDICAL EXAM

MUST BE SIGNED BY A PHYSICIAN

Name:_____ Date:_____

Age:_____ Birth date:_____ Height:_____ Weight:_____

Temperature:_____ Pulse:_____ Respirations:_____ BP:_____

Diagnosis:_____

_____

Allergies:_____

General Appearance:_____

Present Medical Status:_____

Present Medications (including dosage and time of day):_____

_____

_____

_____

_____

DIET:

Food Consistency:_____ Liquid Consistency:_____

Tube Feed Formula (rate/hour or bolus/day):_____

Surgical Procedures/Hospitalizations:_____

_____

_____

EXAM:

Head and Neck:_____

Eyes:_____

Ears:_____

Nose:_____

Mouth and Throat:_____

Chest:_____

Breasts:_____

Lungs:_____

Cardiovascular:_____

Abdomen:_____

Genitalia:_____

Back:_____

Extremities:_____

Skin:_____

Neuro:_____

Station and Gait:_____

Code Status (please circle one): FULL DNR DNRCC DNRCC-arrest

IMMUNIZATION RECORD:

Chicken Pox Vaccine:_____ Polio Vaccine:_____

MMR:_____ Flu Vaccine:_____

DPT:_____ PNEUM Vaccine:_____

COVID-19 Vaccine (type and date):_____

2-step PPD (required before admission):

Date of step 1:_____ Results:_____ MM

Date of step 2:_____ Results:_____ MM

Or recent chest x-ray results:_____

Physician's name (please print):_____

Address:_____

_____

Physician Signature:_____

Date:_____