Physical Exam for Adult Foster Care

Name_____ Date of Exam_____
Age_____ Sex_____ Height_____ Weight_____ Marital Status_____ B-TPR_____

Current Primary Diagnosis:_____
_____
_____
_____
Current Secondary Diagnosis:_____
_____
_____
_____
Chronic Condition (Any illness/condition with recommended treatment): _____
_____
_____
_____
Recommended Treatment:_____
_____
_____
_____

Current Medications:
Resident is capable of administering medications
_____ Yes _____ No

Name_____
Dosage/Frequency_____
Name_____
Dosage/Frequency_____
Name_____
Dosage/Frequency_____

Adverse effects from previous drug (describe):
_____

Medical Condition:

Hepatitis	__Yes	__No	____Year
Mononucleosis	__Yes	__No	____Year
Typhoid Fever	__Yes	__No	____Year
Diabetes	__Yes	__No	____Year
Cancer	__Yes	__No	____Year
Epilepsy	__Yes	__No	____Year
Arthritis	__Yes	__No	____Year
Hypertension	__Yes	__No	____Year
Heart Disease	__Yes	__No	____Year
Surgery(s)	__Yes	__No	____Year

Type:_____
_____
_____
Broken Bones:_____
_____
Treatment (if answer yes to any of fore-mentioned medical conditions):_____
_____

Review To Systems:

	Neg.	Abnormal Findings
Head, Neck, Eyes, Nose, Throat	___	_____
Cardiovascular	___	_____
Abdomen	___	_____
Genitourinary	___	_____
Rectal	___	_____
Extremities	___	_____
Skin	___	_____
Musculoskeletal	___	_____
Lymphatic	___	_____
Neurological	___	_____
Thyroid/Endocrine	___	_____

Assessment: Date/Results/Needs

Dental_____
Hearing_____
Vision_____
Speech_____

Laboratory: Date/Results

Urinalysis_____
Pap Smear_____
Serology_____

Ambulation:

Self___ Assisted___ Appliances/Braces___
Continent___ Incontinent___
(Urine___ Feces___)

Dietary Needs:

Regular____(check)

Restrictions (dietary):_____
_____
_____

Allergies/Sensitivities: _____
_____
_____
_____
_____

Vaccinations (include date of last tetanus shot):

Hospitalization Dates Reason(s)

Free From Communicable Disease:
___Yes ___No _____ (Physician's Signature)

Standard Intradermal Tuberculin Test: (Within past 30 days)

Date_____ Results_____

Previous Positive Mantoux_____
(Date)

Chest X-Ray: (Within past 3 months if Mantoux is positive or contraindicated)

Date_____ Results_____

_____
Hospital Phone

_____
Address

_____
Physician's Name (Print)

Today's Date:_____

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Additional Comments/Information:

MN Rules 9555.6225, Subpart 3. **Physical examination of resident.** The operator must ensure that each resident is examined by a physician no more than 30 days before or within three days after placement in the adult foster home to ensure that the resident is free of the reportable communicable diseases named in parts 4605.7000 to 4605.7800. Transfer records from a health care facility licensed by the Department of Health may be substituted for this requirement.