Department of Family & Community Services
Division of Alaska Pioneer Homes
History and Physical Report
For Active Applications & Active Transfers Only

P.O. Box 112670
Juneau, AK 99811
Ph: 888-355-3117/907-465-4416
Fax: 907-465-4108

Last Name	First Name	Middle Initial	Telephone Number

Mailing Address	City	State	Zip	*Date of Exam*

Date of Birth	Age	Height	Weight

Medical History:

Surgical History:

Family History:

Social History:

Alcohol Use: ☐ Yes ☐ No Tobacco Use: ☐ Yes ☐ No Other Drugs: ☐ Yes ☐ No	Further Information:

Physical Examination

Blood Pressure	Temperature	Pulse	Respiration	O2 Stats

A. General appearance, nutrition, debility, hygiene, etc: _____

B. Head and Neck: _____

C. Nose & Throat: _____

D. Dental: _____

E. Lungs: _____

F. Heart
Vessels: _____
Pulses: _____

G. Abdomen
Liver: _____
Rectum: _____
Hernias: _____

Applicant's Last Name _____ First Name _____ M.I. _____ Date of Exam _____

H. Male Genitourinary

Genitalia: _____

Prostrate: _____

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

☐ Inappropriate, Suicidal, or otherwise dangerous to self or others ☐ Wandering-Requires safeguards

Describe behavior(s) & provide additional information as needed: _____

_____

_____

_____

Q. Neurological

Cranial Nerves: _____

Motor Reflexes: _____

Sensory: _____

Coordination: _____

Vision: _____

Hearing: _____

Applicant's Last Name _____ First Name _____ M.I. _____ Date of Exam _____

Activities of Daily Living

Frequency of Assistance Needed for ADLs

ADL	Never	Occasional	Often	Always
Bathing				
Dressing				
Grooming				
Oral Hygiene				
Toileting				
Eating				
Ambulation				
In/Out of Bed				
Taking Medication				
Walking up/ down stairs				

Extent of Assistance Needed for ADLs

ADL	None	Minimum	Moderate	Max
Bathing				
Dressing				
Grooming				
Oral Hygiene				
Toileting				
Eating				
Ambulation				
In/Out of Bed				
Taking Medication				
Walk up and/or down stairs				

Uses: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other: _____

Activity restrictions? ☐ Yes ☐ No

Dysphagia/Swallowing difficulties? ☐ Yes ☐ No

Is applicant in full control of bladder? ☐ Yes ☐ No

Is applicant in full control of bowels? ☐ Yes ☐ No

Further Information:

Diet

Food Allergies: (Please provide reaction to each food allergy) _____

_____

☐ Regular ☐ Soft ☐ Low-Cal ☐ Low Fat/Low Cholesterol ☐ Salt Restricted ☐ Diabetic

☐ Fluid thickened: Consistency - _____ ☐ Other: _____

Special Instructions: _____

Tuberculosis Status

Note: This section must be completed before admission

Date of Last PPD: _____ Results of Last PPD: _____ _____ mm

If history of positive PPD - CXR: _____ Medication Tx: _____

Immunizations

Date of Administration for the Following Immunizations:

Flu Vaccine: _____ Pneumovax: _____

Diphtheria/Tetanus: _____ Has applicant received complete Dip/Tet series? _____

Hepatitis A: _____ Hepatitis B: _____

Zostavax: _____ COVID-19 Vaccine: _____

Applicant's Last Name _____ First Name _____ M.I. _____ Date of Exam _____

Drug Allergies

Please provide reaction to each allergy:

Medications

Medication	Dosage	Route	Frequency	Diagnosis	ICD10 Code

Please attach additional medication information as needed

Diagnoses

Primary Diagnosis:	ICD10 Code	Onset Date

Please attach additional diagnoses information as needed

Lab Work

Lab work pertinent to current diagnoses:

Prognosis & Therapy Needs (if indicated)

I certify that I examined _____ on _____.

_____ _____

Healthcare Practitioner's signature National Provider Identifier #

_____ _____

Healthcare Practitioner's typed or printed name Street Address

_____ _____ _____ _____

Telephone City State Zip Code