HISTORY AND PHYSICAL REPORT

PO Box 112670, Juneau, AK 99811 | Ph: 888-355-3117 / 907-465-4416 | Fax: 907-465-4108

For Active Applications and Active Transfers Only

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:

Allergies (provide reactions to each):

Family History:

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

Social History:

Alcohol Use: ☐ Yes ☐ No

Tobacco Use: ☐ Yes ☐ No

Other Drugs: ☐ Yes ☐ No

Further Information:

Physical Examination

Blood Pressure | **Temperature** | **Pulse** | **Respiration**

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

B. Head and Neck:

C. Nose and Throat:

D. Dental:

E. Lungs:

F: Cardiovascular:

G. Abdomen:

H. Genitourinary:

I. Lymph:

J. Endocrine:

K. Musculoskeletal:

L. Skin/Wound Care:

M. Psychiatric

Orientation: ☐ A + O x 3 ☐ Occasionally Disoriented ☐ Disoriented

Mood:

Cognition:

Short-Term Memory:

N. Behavior: (Check all that apply)

☐ Appropriate ☐ Inappropriate, Aggressive ☐ Inappropriate, Assaultive ☐ Inappropriate, Passive

☐ Inappropriate, suicidal, or otherwise dangerous to self or others ☐ At risk of causing harm to self or others ☐ Wandering, Requires safeguards

Describe behavior(s) and provide additional information as needed:

O. Neurological

Cranial Nerves: _____

Motor Reflexes: _____

Sensory: _____

Coordination: _____

Vision: _____

Impairment/Devices: ☐ Yes ☐ No

Hearing: _____

Impairment/Devices: ☐ Yes ☐ No

Diet

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

☐ Fluid thickened: Consistency - _____ ☐ Other: _____

Special Instructions:

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

Activities of Daily Living

	Frequency of Assistance Needed				Extent of Assistance Needed			
	Never	Occasional	Often	Always	None	Minimum	Moderate	Maximum
Bathing	○	○	○	○	○	○	○	○
Dressing	○	○	○	○	○	○	○	○
Grooming	○	○	○	○	○	○	○	○
Oral Hygiene	○	○	○	○	○	○	○	○
Toileting	○	○	○	○	○	○	○	○
Eating	○	○	○	○	○	○	○	○
Ambulation	○	○	○	○	○	○	○	○
In/Out of Bed	○	○	○	○	○	○	○	○
Taking Medication	○	○	○	○	○	○	○	○
Walking Up / Down Stairs	○	○	○	○	○	○	○	○

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

Activity restrictions? ☐ Yes ☐ No

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

Dysphagia/Swallowing difficulties? ☐ Yes ☐ No

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

Further information:

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: _____ COVID-19: _____ RSV: _____

Shingles: _____ Pneumonia: _____ HPV: _____

Tdap: _____ Hepatitis A: _____ Hepatitis B: _____

Meningitis: _____ MMR: _____ Other: _____

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Medications

Name	Dosage	Route	Frequency	Diagnosis	ICD10 Code

Please attach additional medication information as needed.

Diagnoses

Primary Diagnosis:	Onset Date	ICD10 Code
Secondary Diagnoses:		

Please attach additional diagnoses information as needed.

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Code Status

☐ Hospice (End of Life Care)

☐ DNR

☐ Comfort One

Further information:

Lab Work

Lab work pertinent to current diagnoses:

Prognosis

Rehabilitation/Therapy Needs

Is a therapy regimen necessary to maintain or increase patient function, mobility, or independence? ☐ Yes ☐ No

Describe:

Certification

I certify that I examined _____ (First Name) _____ (Applicant's Last Name) on _____ (Date of Exam)

Healthcare Practitioner's signature | National Provider Identifier # | Mailing Address

Healthcare Practitioner's printed name | Phone | City | State | Zip