THE FOREST AT DUKE

PRIVATE AND CONFIDENTIAL

# Physician's Health Assessment for Residency

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**TO BE COMPLETED BY APPLICANT'S PHYSICIAN**

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**As part of the admission process for The Forest at Duke** continuing care retirement community, a health assessment of each applicant is required prior to residency. Please review your medical records for your patient named below, perform a complete physical examination, and assess the person's ability to function in the areas indicated. If additional space is needed, or if you prefer, you may attach copies of your records and/or a summary letter. Thank you.

**Please detach individual pages and fax completed forms to 919-433-2367, or mail to The Forest at Duke Marketing Department / 2701 Pickett Road / Durham, NC 27705**

## APPLICANT INFORMATION

PATIENT _____ DOB _____

PATIENT SINCE _____ HOW OFTEN SEEN? _____ WHEN LAST TREATED? _____

## ACTIVE MEDICAL / PSYCHIATRIC CONDITIONS

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

## CURRENT MEDICATIONS

| | DOSE | SCHEDULE | INDICATION |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

☐ CHECK HERE IF MORE ARE NOTED ELSEWHERE.

## DRUG ALLERGIES

| | TYPE OF REACTION |
|---|---|
| 1. | |
| 2. | |
| 3. | |

## MEDICAL HISTORY (please note a history and date of onset of any of the following conditions)

| | ONSET DATE | EXPLANATION | CURRENT STATUS |
|---|---|---|---|
| ☐ Cancer | | | |
| ☐ Seizures | | | |
| ☐ Lung disease | | | |
| ☐ Heart disease | | | |
| ☐ Psychiatric disease | | | |
| ☐ Fractures | | | |
| ☐ Kidney disease | | | |
| ☐ Eye disease | | | |
| ☐ TIA or stroke | | | |
| ☐ Liver disease | | | |
| ☐ Head injury | | | |
| ☐ Alzheimer's/dementia | | | |
| ☐ Parkinson's | | | |
| ☐ ALS | | | |
| ☐ Other | | | |

## SURGICAL HISTORY

| PROCEDURE | APPROX. YEAR | PROCEDURE | APPROX. YEAR |
|---|---|---|---|
| 1. | | 2. | |
| 3. | | 4. | |

Explain if any surgery has been recommended but not performed:

List any hospitilizations for the past two years:

## IMMUNIZATION RECORD

| | DATE | | DATE |
|---|---|---|---|
| Influenza yearly | | Pneumovax | |
| Tetanus / diptheria (required within 10 yrs) | | Shingles | |

## PHYSICAL EXAM

| WEIGHT | HEIGHT | BLOOD PRESSURE | HEART RATE |
|---|---|---|---|
| | | | |

| GENERAL APPEARANCE | NL | ABN | Check NL or ABN • Circle / describe abnormals |
|---|---|---|---|
| **SKIN** Rash, Suspicious Mole, Lesions, Keratosis, Turgor, Color | ☐ | ☐ | |
| **HEENT** Nose, Septum, Ear Canal, Drum, Hearing, Eyes, Vision, Sciera, Conjunctiva, Fundi, Pupils, Cataract, Oropharynx, Mucosa, Tongue, Teeth, Gums | ☐ | ☐ | |
| **NECK** Thyroid, NP, Carotids, Bruits | ☐ | ☐ | |
| **CHEST/LUNGS** Shape, Expansion, Tenderness, Breath sounds, Rales, Rhonchi, Wheezing | ☐ | ☐ | |
| **HEART** Sounds, Rhythm, Gallops, Murmur, Rub, Rate | ☐ | ☐ | |
| **BREAST** Tender, Mass, Nipple | ☐ | ☐ | |
| **MALE GENITALIA** Testicles, Penis, Scrotum | ☐ | ☐ | |
| **FEMALE GENITALIA** Vulva, Vagina, Cervix, Uterus, Achnexa, Mass, Discharge | ☐ | ☐ | |
| **RECTAL** Hemorrhoids, Mass, Blood | ☐ | ☐ | |
| **PROSTATE** Enlarged, Mass, Tender | ☐ | ☐ | |
| **HERNIA** Location, Tender, Reducible | ☐ | ☐ | |
| **EXTREMITIES** Edema, Ulcer, Color, Varicosities, Femoral, Popliteal, DP, PT Pulses | ☐ | ☐ | |
| **MUSC-SKEL** Spine, Kyphoscoliosis, Joints, Hands, Shoulders, Hips, Knees, Ankles, Lumbosacral | ☐ | ☐ | |
| **NEURO** Mental Status, Memory, Tremor, Reflexes, Motor, Sensory, Coordination, Gait, Nystagmus | ☐ | ☐ | |
| **LYMPH NODES** Cervical, Axillary, Inguinal | ☐ | ☐ | |

## FUNCTIONAL ASSESSMENT FOR ACTIVITIES OF DAILY LIVING (ADL)

**Please indicate below the applicant's functional abilities by circling the appropriate letter.**

**I** Independent: Able to do the activity unassisted
**A** Assistance required to accomplish the activity
**D** Dependent: Cannot do the activity; it is done by others
**N** Never performed this activity; not relevant

| INSTRUMENTAL ADL | | Comments |
|---|---|---|
| Telephone use | I A D N | |
| Medicines taken properly | I A D N | |
| Transportation via car/bus/cab | I A D N | |
| Shopping for groceries/clothes | I A D N | |
| Meal preparation | I A D N | |
| Housework | I A D N | |
| Personal finance management | I A D N | |
| **PHYSICAL ADL** | | **Comments** |
| Eating properly, regularly | I A D N | |
| Hygiene | I A D N | |
| Transfers (bed to chair, etc) | I A D N | |
| Toileting | I A D N | |
| Continence | I A D N | |
| Bathing | I A D N | |
| Dressing | I A D N | |
| Grooming | I A D N | |
| Walking | I A D N | |

## COGNITIVE STATUS

Please indicate functional ability.
**A** Always
**S** Sometimes
**N** Never

| | | Comments |
|---|---|---|
| Oriented | A S N | |
| Cooperative | A S N | |
| Follows directions | A S N | |
| Able to respond to emergencies | A S N | |

Is there any evidence of cognitive impairment? ☐ Yes ☐ No **If yes, please explain:**

Is there any evidence of parkinsonism? ☐ Yes ☐ No **If yes, please explain:**

Please list any assistive aids that your patient is currently using, e.g., hearing aids, glasses, prostheses, cane, walker, wheelchair, or motorized scooter:

Does your patient use any of the following?

| | ONSET DATE | | ONSET DATE |
|---|---|---|---|
| ☐ Catheters | | ☐ Feeding tube | |
| ☐ Colostomy bag | | ☐ Tracheal tube | |

In your opinion, do you feel this applicant is appropriate for independent living for greater than three years?

☐ Yes ☐ No

Please note any concerns for your patient:

**LABS REQUIRED WITHIN SIX MONTHS PRIOR TO MOVE-IN.** *Please fax lab results to 919-433-2367.*

☐ CBC ☐ Complete Metabolic Panel

PHYSICIAN'S NAME (PLEASE PRINT)

ADDRESS PHONE FAX

SIGNATURE DATE

THE FOREST AT DUKE
2701 Pickett Road, Durham, NC 27705 / 919-490-8000 / 800-474-0258 / 919-433-2367 fax