Non-Profit Organisation No. 012-017 NPO

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Private & Confidential

MEDICAL REPORT – INTAKE FORM

FULL NAME ……

DATE OF BIRTH ……………………………………………………………………………………………………..

ADDRESS …….

PREVIOUS MEDICAL HISTORY

(Please complete relevant item/s and provide year of occurrence)

Alimentary System	**Yes/No**	***Year of Occurrence***	***Alimentary System***	**Yes/No**	***Year of occurrence***
Peptic ulcer			Chronic dyspepsia		
Colitis			Appendicitis		
Cholecystitis			Other		
Cardio-Vascular System	**Yes/No**	**Year of Occurrence**	***Cardio-Vascular System***	**Yes/No**	***Year of Occurrence***
Coronary Thrombosis			Hypertension		
Congestive failure			Rheumatic fever		
Anaemia			Peripheral vascular disease		
Varicose veins			Other		

Blood Pressure **(Please provide details)**					
Blood Type					
Respiratory System	***Yes/No***	***Year of occurrence***	***Respiratory System***	***Yes/No***	***Year of Occurrence***
Bronchitis			Pneumonia		
Asthma			Pneumoconiosis		
Tuberculosis			Sinusitis		
Emphysema			Other		
Genito-Urinary System	***Yes/No***	***Year of Occurrence***	***Genito-Urinary System***	***Yes/No***	***Year of Occurrence***
Nephritis			Renal-calculus		
Cystitis			Prostatism		
Stricture			Cervicitis		
Prolapse of uterus & virginal wall			Benign tumours		
Salpingitis			Incontinency		
Urine analysis			Other		
Nervous System	***Yes/No***	***Year of Occurrence***	***Nervous System***	***Yes/No***	***Year of Occurrence***
Cerebro-vascular accidents			Epilepsy		
Paralysis agitans			Peripheral neuritis		
Fainting episodes			Other		
Metabolic	***Yes/No***	***Year of Occurrence***	***Metabolic***	***Yes/No***	***Year of Occurrence***
Weight			Obesity		
Thyroid disorders			Diabetes		
Vitamin deficiency			Other		
Muscular Skeletal System	***Yes/No***	***Year of Occurrence***	***Muscular Skeletal System***	***Yes/No***	***Year of Occurrence***
Previous injury			Osteoarthritis		
Osteoporosis			Rheumatoid arthritis		
Bone density loss %			Osteitis		
Re-absorptive medication			Wasting or weakness		
Deformity due to any cause			Other		
Risk of osteoporotic fractures/ frailty fractures: Low ☐ Medium ☐ High ☐					
Skin	***Yes/No***	***Year of Occurrence***	***Skin***	***Yes/No***	***Year of Occurrence***

Dermatitis Tumours			Eczema Other		
Cancer (please specify)					
Benign tumours (please describe if applicable)					
Allergies (please list)					
Sight	***Yes/No***	***Year of Occurrence***	***Sign***	***Yes/No***	***Year of Occurrence***
Cataract Glaucoma			Vision corrected Vision uncorrected		
Hearing	***Yes/No***	***Year of Occurrence***	***Hearing***	***Yes/No***	***Year of Occurrence***
Otitis media (please describe)			Osteosclerosis (please describe)		
SURGICAL					
Operations (Please provide details)					
Accidents (List cause, nature of injury & residual effects)					
MENTAL CONDITION					
Psychotic episodes	***Yes/No***	***Year of Occurrence***	***Psychotic episodes***	***Yes/No***	***Year of occurrence***
Bipolar depressive			Toxic psychosis		
Obsession			Senile degenerative		
Schizophrenic			Reactive depression		
Psycho-neurotic			Shock treatment		
Describe present mental condition:					
Addictions	***Yes/No***	***Year of Occurrence***	***Addictions***	***Yes/No***	***Year of Occurrence***
Tobacco			Alcohol		
Drugs			Other		
Please provide details:					

GENERAL CONDITION (Please provide details where applicable)		
Takes care of self completely	Yes/No	
Needs some help for dressing/eating	Yes/No	
Diabetic	Yes/No	
Heart	Yes/No	
Partially bedridden	Yes/No	
Completely bedridden	Yes/No	
Uses wheelchair	Yes/No	
Deaf / Partially deaf	Yes/No	
Blind / Partially blind	Yes/No	
Other conditions:		

DOCTOR'S SCRIPTS
Please attach a valid doctor's script (essential)
Script attached Yes ☐ No ☐

RECOMMENDED TREATMENT			
Physiotherapy	Yes/ No	Health Massages	Yes/No
Physical exercises	Yes/No	Skills Dev/Hobbies	Yes/No
Meditation/yoga	Yes/No	Other (please describe)	

DOCTOR'S RECOMMENDATION (please tick which option is best for this patient)	
Residential Living (laundry & meals provided)	☐
Assisted Care (laundry, meals plus limited nursing assistance)	☐
Full Care (24-hour nursing care)	☐

I have known & treated Mr/Ms ………………………………………………………………………. since …………… (year) and my report is as set out above.

Date: ………………………………………………… **Tel: ……………………………………………………….**

Address: ……….

Doctor's Signature: ………………………………………………………………………………………………