



Non-Profit Organisation No. 012-017

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

Blood Pressure (Please provide details)					
Blood Type					
Respiratory System	Yes/No	Year of occurrence	Respiratory System	Yes/No	Year of Occurrence
Bronchitis	NO		Pneumonia	NO	
Asthma	NO		Pneumoconiosis	NO	
Tuberculosis	NO		Sinusitis	NO	
Emphysema	NO		Other	NO	
Genito-Urinary System	Yes/No	Year of Occurrence	Genito-Urinary System	Yes/No	Year of Occurrence
Nephritis	NO		Renal-calculus	NO	
Cystitis	NO		Prostatism	NO	
Stricture	NO		Cervicitis	NO	
Prolapse of uterus & virginal wall	NO		Benign tumours	NO	
Salpingitis	NO		Incontinency	NO	
Urine analysis	NO		Other	NO	
Nervous System	Yes/No	Year of Occurrence	Nervous System	Yes/No	Year of Occurrence
Cerebro-vascular accidents	NO		Epilepsy	NO	
Paralysis agitans	NO		Peripheral neuritis	NO	
Fainting episodes	NO		Other	NO	
Metabolic	Yes/No	Year of Occurrence	Metabolic	Yes/No	Year of Occurrence
Weight	NO		Obesity	NO	
Thyroid disorders	NO		Diabetes	NO	
Vitamin deficiency	NO		Other	NO	
Muscular Skeletal System	Yes/No	Year of Occurrence	Muscular Skeletal System	Yes/No	Year of Occurrence
Previous injury	NO		Osteoarthritis	NO	
Osteoporosis	NO		Rheumatoid arthritis	NO	
Bone density loss %	0%		Osteitis	NO	
Re-absorptive medication	NO		Wasting or weakness	NO	
Deformity due to any cause	NO		Other	NO	
Risk of osteoporotic fractures/ frailty fractures: Low ☐ Medium ☐ High ☐					
Skin	Yes/No	Year of Occurrence	Skin	Yes/No	Year of Occurrence

Dermatitis	NO		Eczema	NO	
Tumours	NO		Other	NO	
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	NO		Vision corrected	NO	
Glaucoma	NO		Vision uncorrected	NO	
Hearing	Yes/No	Year of Occurrence	Hearing	Yes/No	Year of Occurrence
Otitis media (please describe)	NO		Osteosclerosis (please describe)	NO	
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	NO		Toxic psychosis	NO	
Obsession	NO		Senile degenerative	NO	
Schizophrenic	NO		Reactive depression	NO	
Psycho-neurotic	NO		Shock treatment	NO	
Describe present mental condition:					
Addictions	Yes/No	Year of Occurrence	Addictions	Yes/No	Year of Occurrence
Tobacco	NO		Alcohol	NO	
Drugs	NO		Other	NO	
Please provide details:					

GENERAL CONDITION (Please provide details where applicable)		
Takes care of self completely	Yes/No	NO
Needs some help for dressing/eating	Yes/No	NO
Diabetic	Yes/No	NO
Heart	Yes/No	NO
Partially bedridden	Yes/No	NO
Completely bedridden	Yes/No	NO
Uses wheelchair	Yes/No	NO
Deaf / Partially deaf	Yes/No	NO
Blind / Partially blind	Yes/No	NO
Other conditions:		
DOCTOR'S SCRIPTS		
Please attach a valid doctor's script (essential)		
Script attached	Yes ☒	No ☒
RECOMMENDED TREATMENT		
Physiotherapy	NO	Yes/ No
Physical exercises	NO	Yes/No
Meditation/yoga	NO	Yes/No
Health Massages	Yes/No	NO
Skills Dev/Hobbies	Yes/No	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: