

Hopewell Medical History and Physical

(440) 693-4074

This form is to be completed as an initial part of the admission assessment process and annually thereafter. Candidates need to demonstrate a level of health that allows for physical work on a farm and ability to safely navigate between buildings over uneven ground.

PATIENT INFORMATION:

Last name: _____ MI: _____ First Name: _____

Date of Birth: _____ Age: _____ Gender: F M T

Home Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail: _____

Home # _____ Work # _____ Cell# _____

MEDICAL HISTORY

Family History: Please identify biologically related family members who have had any of the following conditions:

| Disease Type | Family Members Diagnosed | Deceased? Yes or No |
|-------------------------|---------------------------------|----------------------------|
| Osteoporosis | | |
| Cancer (specify type) | | |
| Bleeding Disorder | | |
| Diabetes | | |
| Genetic Disorder | | |
| Cardiovascular Diseases | | |
| Pulmonary Diseases | | |

Patient Allergies:

| | <u>List Allergies</u> | <u>List Reactions</u> |
|--------------------------------|------------------------------|------------------------------|
| Medication Allergies | | |
| Food Allergies | | |
| Environmental Allergies | | |

Medications and Supplements:

Please list ALL medications including as necessary meds, nutritional supplements, herbs, vitamins and over the counter meds (use back of sheet if necessary):

Standing Medications:

| Name | Dose | Time | Reason | Prescriber |
|------|------|------|--------|------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

PRN meds (include OTC):

| Name | Dose | Time | Reason | Prescriber |
|------|------|------|--------|------------|
| | | | | |
| | | | | |
| | | | | |

Nutritional supplements:

| Name | Dose | Time | Reason | Prescriber |
|------|------|------|--------|------------|
| | | | | |
| | | | | |
| | | | | |

Accidents: Please list any past accidents with major injuries, falls with injuries, fractures or dislocations, head injuries:

| Year | Event | Injury |
|------|-------|--------|
| | | |
| | | |
| | | |

Surgeries and hospitalizations: Please list any surgeries and medical hospitalizations:

| Year | Event | Hospital |
|------|-------|----------|
| | | |
| | | |
| | | |

Substance use: If history exists we may request a urine drug screen prior to admission (except for nicotine & caffeine).

| Type: | Amount: | Type: | Last use: |
|-----------------|---------|-------|-----------|
| Alcohol | | | |
| Cocaine | | | |
| Opioids | | | |
| Amphetamines | | | |
| Marijuana | | | |
| Barbiturates | | | |
| Benzodiazepines | | | |
| “Club” drugs | | | |
| Nicotine | | | |
| Caffeine | | | |
| Psychedelics | | | |
| Inhalants | | | |

REVIEW OF MEDICAL SYSTEMS

Check this box if previously had and provide dates if known in comment section

Check this box if currently has

Integumentary

- Skin rashes Psoriasis Skin cancer Piercings Scars
- Slow healing Herpes Discolorations Changes in moles Bruise easily
- Pruritis Sores Tattoos

Comments: _____

Neurological

- Syncope Disorientation Weakness Confusion
- Memory Loss Concussion Loss of coordination Numbness
- Difficulty speaking Headaches Difficulty walking Tingling
- Multiple Sclerosis Migraines Stroke Tremors
- Parkinson’s Disease Epilepsy Dementia Cerebral palsy
- Dizziness Seizures

Comments: _____

Sensory

- Glaucoma Ear pain Cataracts Dental problems
- Blurred vision Hearing loss Double vision Ear noises
- Glasses Contacts Dentures Hearing Aide
- Loss of smell

Last dental appointment: _____ Dentist: _____

Last vision exam: _____ Doctor: _____

Comments: _____

Respiratory

- Nose bleeds Hoarseness Sore throats
- Coughing Pneumonia Bronchitis Sinusitis
- Hematamesis Difficulty breathing Emphysema SOB
- Asthma Tuberculosis Lung cancer

Last TB test: _____ Results: _____

Last chest X-ray: _____ Results: _____
Comments: _____

Endocrine

Hypothyroidism Hyperthyroidism Diabetes Goiter

Comments: _____

Cardiovascular

Hypertension Aneurysm Chest pain
 Heart attack Hypotension Edema
 Irregular heartbeat Cardiomegaly High triglycerides
 Murmurs High cholesterol levels Rheumatic fever

Comments: _____

Gastrointestinal

Cholecystitis Constipation GERD Encopresis
 Liver trouble Diarrhea Colostomy Hematemesis
 Hepatitis Ulcers Hiatal hernia Pancreatitis
 Heartburn Colitis Colon cancer Melena/Hematochezia
 Weight Loss Weight gain Loss of appetite Vomiting

Swallowing problems

Diet: _____

Comments: _____

Genitourinary

Painful urination Frequent urination Kidney infection Kidney stones
 Hematuria Incontinence Urostomy

Comments: _____

Hematologic

Anemia Bleeding disorder Sickle cell anemia Lymphoma
 Clotting issues History of clots

Comments: _____

Musculoskeletal

Arthritis Head injury Fibromyalgia
 Osteoarthritis Neck injury Muscle weakness Gout
 Rheumatoid arthritis Back injury Osteoporosis Scoliosis
 Spinal trauma Muscular dystrophy Lupus
 Birth trauma Spina bifida Polio
 Fractures Birth defects Spondylothiasis

Comments: _____

Immunologic

Routine childhood immunizations Tetanus
 MRSA Vaccinations
 HIV AIDS

Comments: _____

Women only

Nipple discharge Premenstrual depression Menopause STD
 Menstrual cramps Lumps in breasts Perimenopause LMP
 Vaginal discharge Pap smear Hysterectomy Mammogram
 HCG

Comments: _____

Men only

Nightly urination Prostate trouble STD ED
 Difficulty starting urine Dripping after urination Prostate cancer

Comments: _____

Please provide current vital signs

Height: _____ Weight: _____

BP: sit _____ stand _____ P: _____ R: _____ T: _____

Healthcare Provider name: (print) _____ Title _____ Date _____

Healthcare Provider Signature_____