JOHN GEORGE HOME, INC

1501 EAST GANSON STREET ♦ JACKSON, MICHIGAN 49202
517.783.4134 ♦ 517.783.0872 FAX

MEDICAL REPORT

NOTE: MICHIGAN LAW AND THE POLICIES OF THIS FACILITY REQUIRE A PRE-ADMISSION HISTORY & PHYSICAL, AS WELL AS A CHEST X-RAY REPORT (WITHIN 3 MONTHS PRIOR TO ADMISSION). PLEASE COMPLETE BOTH PAGES OF THIS REPORT AND RETURN WITHIN TWO BUSINESS DAYS TO THE JOHN GEORGE HOME.

PATIENT NAME: ____ DOB: ____/____/____ AGE: ____

ALL CURRENT DIAGNOSES

1. ________________________________ 2. ________________________________
3. ________________________________ 4. ________________________________
5. ________________________________ 6. ________________________________

CURRENT MEDICATIONS (RX & OTC) WITH DIRECTIONS (ATTACH SHEET IF NEEDED)

1. ________________________________ 2. ________________________________
3. ________________________________ 4. ________________________________
5. ________________________________ 6. ________________________________
7. ________________________________ 8. ________________________________
9. ________________________________ 10. ________________________________

PAST SURGIES:

____

ALLERGIES TO MEDICATIONS: ____

ALLERGIES TO FOOD: ____

IMMUNIZATION HISTORY (INDICATE DATE)

___/___/___ PNEUMOVAX ___/___/___ TETANUS, DIPTHERIA, TOXOID ___/___/___ INFLUENZA VACCINE

TB STATUS: __________ LAST PPD: ___/___/___ RESULTS: __________ CXR ORDERED: ___/___/___

OTHER COMMUNICABLE DISEASE? ☐ YES ☐ NO IF YES, WHAT? ______________________________

DIET: REGULAR DIET ____ DIABETIC ____ NO CONCENTRATED SWEETS ____ NO SALT ADDED ____

ASSISTIVE DEVICES: WALKER ____ CANE ____ WHEELCHAIR ____

OTHER REMARKS: ____

____

______________________ ______________________ ____________
PHYSICIAN NAME (PRINTED) PHYSICIAN SIGNATURE DATE

______________________ ______________ ________ ________
STREET ADDRESS CITY STATE ZIP

_____._____._____ _____._____._____
PHONE FAX

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PHYSICAL EXAMINATION

DATE: _____/_____/_____

PATIENT NAME: ____ DOB: _____/_____/_____

BP: _____/_____ HT: _____′ _____″ T: ______ P: _____ R: _____ URINE: _____

	NORMAL	ABNORMAL	COMMENTS
1. GENERAL APPEARANCE	□	□	____________________________
2. SKIN	□	□	____________________________
3. LYMPH NODES	□	□	____________________________
4. HEAD	□	□	____________________________
5. EYES (GLASSES?)	□	□	____________________________
6. EARS (HEARING AID?)	□	□	____________________________
7. NOSE	□	□	____________________________
8. MOUTH/THROAT (DENTURES)	□	□	____________________________
9. NECK	□	□	____________________________
10. BACK	□	□	____________________________
11. CHEST	□	□	____________________________
12. HEART (PACEMAKER?)	□	□	____________________________
13. ABDOMEN	□	□	____________________________
14. EXTREMETIES (ARTIFICAL LIMBS?)	□	□	____________________________
15. RECTAL	□	□	____________________________

ADDITIONAL COMMENTS/ORDERS

____

____

____

____

____

____________________________________ PHYSICIAN SIGNATURE

____________________ DATE