# MEDICAL EVALUATION

All Spaces Must Be Filled Out

Resident's Name: _____

Facility Name: _____ Date of Birth: _____

Present Home Address: _____

## MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse: _____ Resp: _____ T: _____ Height: _____ ft _____

Primary Diagnosis(s) : _____

_____

Secondary Diagnosis(s): _____

_____

Allergies: None or list Known Allergies:

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Other: _____

Immunizations: ☐ Influenza (Date _____) ☐ Pneumococcal Vaccine (date__)

**TB SCREENING** (performed **within 30 days prior to initial admission** unless medically)

☐ Test is contraindicated Test: ☐ TST1 ☐ TST2 ☐ TB Blood Test(Type) _____

TST: Date placed _____ Date Read _____ mm _____ TST2: date placed _____