

United Methodist Homes of New Jersey

PREADMISSION & ANNUAL MEDICAL HISTORY & PHYSICAL

Name:			
Address:			
Telephone Number:		Date of Birth:	
Has applicant/resident been in a: <i>Hospital</i> <input type="checkbox"/> <i>Nursing Home</i> <input type="checkbox"/>			
For what reason?			
Are you the applicant's / resident's regular physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
List all medications which applicant/ resident is presently taking			
Any Special Care Needs :			
History			
History Of:			
Allergies			
Diabetes		Cancer	Type
Cardiac	Respiratory Illness	Tuberculosis	Prostate Disease
Paralysis/ Weakness		Where	
Fractures		Location	When
Surgeries		When	Reason
Chronic Illness			
Mental And Emotional Health			
Prosthesis			
Dietary Needs (Please Circle One):			
NO SALT ADDED	NO CONCENTRATED SWEETS	REGULAR	

Physical Examination

Height		Weight	Temperature	Blood Pressure
Head	Scalp	Nose	Gums	Ears
	Eyes	Throat	Tongue	Teeth

Neck	Nodes	Thyroid
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Chest	Breasts	Lungs
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Abdomen	Hernia	Genitalia	Rectum
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Extremities	Skin
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Neurological:

Diagnosis :

Remarks and Recommendations:

Physician (Please Print)	Date of Examination
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Full Address	Telephone Number
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Physician Signature_____