

**Physical Exam for Adult Foster Care**

Name \_\_\_\_\_ Date of Exam \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_ B-TPR \_\_\_\_\_

Current Primary Diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Secondary Diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Chronic Condition (Any illness/condition with recommended treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Recommended Treatment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Medications:  
 Resident is capable of administering medications  
 \_\_\_\_\_ Yes \_\_\_\_\_ No

Name \_\_\_\_\_  
 Dosage/Frequency \_\_\_\_\_  
 Name \_\_\_\_\_  
 Dosage/Frequency \_\_\_\_\_  
 Name \_\_\_\_\_  
 Dosage/Frequency \_\_\_\_\_

Adverse effects from previous drug (describe):  
 \_\_\_\_\_

Medical Condition:  
 Hepatitis            \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Mononucleosis      \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Typhoid Fever      \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Diabetes            \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Cancer              \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Epilepsy            \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Arthritis            \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Hypertension        \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Heart Disease        \_\_\_ Yes \_\_\_ No    \_\_\_ Year  
 Surgery(s)          \_\_\_ Yes \_\_\_ No    \_\_\_ Year

Type: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Broken Bones: \_\_\_\_\_  
 \_\_\_\_\_

Treatment (if answer yes to any of fore-mentioned medical conditions): \_\_\_\_\_  
 \_\_\_\_\_

Review To Systems:

	<u>Neg.</u>	<u>Abnormal Findings</u>
Head, Neck, Eyes, Nose, Throat	_____	_____
Cardiovascular	_____	_____
Abdomen	_____	_____
Genitourinary	_____	_____
Rectal	_____	_____
Extremities	_____	_____
Skin	_____	_____
Musculoskeletal	_____	_____
Lymphatic	_____	_____
Neurological	_____	_____
Thyroid/Endocrine	_____	_____

Assessment: Date/Results/Needs

Dental \_\_\_\_\_  
 Hearing \_\_\_\_\_  
 Vision \_\_\_\_\_  
 Speech \_\_\_\_\_

Laboratory: Date/Results

Urinalysis \_\_\_\_\_  
 Pap Smear \_\_\_\_\_  
 Serology \_\_\_\_\_

Ambulation:

Self \_\_\_ Assisted \_\_\_ Appliances/Braces \_\_\_  
 Continent \_\_\_ Incontinent \_\_\_  
 (Urine \_\_\_ Feces \_\_\_)

Dietary Needs:

Regular \_\_\_ (check)

Restrictions (dietary): \_\_\_\_\_  
 \_\_\_\_\_

Allergies/Sensitivities: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Vaccinations (include date of last tetanus shot): \_\_\_\_\_  
\_\_\_\_\_

<u>Hospitalization</u>	<u>Dates</u>	<u>Reason(s)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Free From Communicable Disease:  
\_\_\_ Yes \_\_\_ No \_\_\_\_\_ (Physician's Signature)

Standard Intradermal Tuberculin Test: (Within past 30 days)

Date _____	Results _____	_____	_____
Previous Positive Mantoux _____		Hospital	Phone
(Date)		Address	

Chest X-Ray: (Within past 3 months if Mantoux is positive or contraindicated) \_\_\_\_\_  
Physician's Name (Print)

Date \_\_\_\_\_ Results \_\_\_\_\_ Today's Date: \_\_\_\_\_

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Additional Comments/Information:

MN Rules 9555.6225, Subpart 3. **Physical examination of resident.** The operator must ensure that each resident is examined by a physician no more than 30 days before or within three days after placement in the adult foster home to ensure that the resident is free of the reportable communicable diseases named in parts 4605.7000 to 4605.7800. Transfer records from a health care facility licensed by the Department of Health may be substituted for this requirement.