



**Shoreham Village Assisted Living**  
**Medical Assessment**

**Please Print:**

Applicant: \_\_\_\_\_ HCN: \_\_\_\_\_

**Active Diagnoses:**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

Drug/Food Allergies: \_\_\_\_\_

MRSA Checked?    Yes        No        Result: \_\_\_\_\_

VRE Checked?     Yes        No        Result: \_\_\_\_\_

Other Infection Control issues, please specify: \_\_\_\_\_

\_\_\_\_\_

Medical problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any changes in health status in last six (6) months:    Yes        No

If yes, explain \_\_\_\_\_

\_\_\_\_\_

(over)

Any recent medication changes:    Yes            No

Recent surgeries: \_\_\_\_\_

If Applicant is in hospital, admission date: \_\_\_\_\_

Name of hospital: \_\_\_\_\_

<b><i>Medications: (Include OTCs)</i></b>	<b><i>Dosage:</i></b>	<b><i>Frequency:</i></b>	<b><i>Route:</i></b>

Date of Pneumococcal Vaccine: \_\_\_\_\_

Date of Influenza Vaccine: \_\_\_\_\_

If on anticoagulant therapy, frequency of INRs: \_\_\_\_\_

If Code Status has been established, please clarify: \_\_\_\_\_

Other comments: \_\_\_\_\_

Are you the Applicant's family Physician?    Yes            No

If no, name of family Physician? \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

