MS STATE VETERANS AFFAIRS BOARD

3466 Hwy 80 East
P.O. Box 5947
Pearl, Mississippi 39285-5947

Note: Please have your physician complete the enclosed Medical History, Physical Form, and the Statement of Attending Physician's Form. All questions on these forms must be answered. These forms should be returned along with your application package.

MEDICAL HISTORY AND PHYSICAL

(Must be completed within thirty (30) days prior to applying for admission to the State Veterans Home)
Applicant's Name: _____ SSN_____
Applicant's Address: _____
_____

PERTINENT MEDICAL HISTORY

Diabetes _____ Epilepsy _____ Arthritis _____ Body/Organ Donor _____

	LAST DIAGNOSIS	DATE
Kidney:	_____	_____
CVA:	_____	_____
Chest X-Ray:	_____	_____
Tuberculosis:	_____	_____
Other lung condition:	_____	_____
Heart:	_____	_____
Cancer:	_____	_____

Pneumonia Vaccine: Date: _____
Flu Vaccine: Date: _____
Mental illness: Yes ___ No ____

Periods of Hospitalization: _____
Name of Hospital: _____
Address: _____

Seizure Disorder: _____
Wanderer: _____
Other Disease(please specify): _____

Permanent Disabilities: _____
Operations:
_____
Habits: coffee ___ tea ___ smoke ___ alcohol ___ narcotics ___
Dietary History: _____
Drug Sensitivity: _____
Allergies: _____

Living Will: _____
Medical/Durable Power of Attorney (if yes, please attach copy): _____

Continence:
___Continent ___Incontinent feces
___Continent, urine only ___Incontinent urine
___Continent, feces only ___Incontinent, both

Current Medications:
_____
_____
_____
_____

Restorative Treatment:
_____
_____
_____

Chief Complaints: (current)_____
_____
_____
_____

Most Recent Attending Physician: _____
Address:
_____
_____
_____
Phone Number: _____

EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____
Age: _____ Sex: _____ Temperature: _____
Pulse: _____ Respiration: _____

Physical Condition: ___Good __ Fair ____Poor
Mental Condition: ___Clear __ Partly Confused ____Badly Confused
Ambulation: ___Self __ Assisted ____Non Ambulatory

Eyes-Ears-Teeth: _____

X-Ray, Biopsy, Lab Analysis, etc.:_____
_____
_____

Behavior Problems:_____
_____
_____
_____

Communicable disease? Yes _____ No _____
If yes, explain: _____
_____
_____

Skin condition to include decubitus: _____
_____

Explain any other special problems, such as emotional disorders, speech, paralysis, arthritic, or arteriosclerosis condition: _____
_____

Functional limitations or special needs, such as resident has glasses, dentures, or prosthesis, requires help getting in and out of bed, etc.: _____
_____
_____
_____

Admission Diagnosis: _____
_____

Admitting Orders: (include medications, diet, treatment, restorative measures, short and long term goals)
_____
_____
_____
_____

Physician's Signature _____Date _____