MISSISSIPPI STATE VETERANS HOME

310 Autumn Ridge Dr.
Kosciusko, Mississippi 39090

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 (mm/dd/yyyy)
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 _____