La Residence Fulford Residence

1221 Guy Street
Montréal, QC H3H 2K8
514 933 7975

CONFIDENTIAL

To be completed by doctor

Date: _____

1 GENERAL INFORMATION

Full name of applicant: Mrs. ☐ Miss ☐ _____
(Surname - please print) *(Given names)*

Address: _____
(Street and number or R.R.) *(City, town, village or post office)* *(Postal code)*

Date of birth: _____ *(Month/Day/Year)*

Marital status: Single ☐ Married ☐ Widow ☐

List family members: _____
(Name) *(Address)* *(Telephone)*

2 PAST MEDICAL HISTORY

3 PAST SURGICAL HISTORY

4 PRESENT HEALTH AND SYMPTOM INQUIRY (check ✓)

	Yes	No		Yes	No
Loss of hearing	☐	☐	Indigestion or abdominal distress	☐	☐
Difficulty with vision	☐	☐	Change in bowel habits or shape of stools	☐	☐
Difficulty with teeth (natural or false)	☐	☐	Incontinence or nocturia	☐	☐
Cough	☐	☐	Urinary frequency or urgency	☐	☐
Shortness of breath	☐	☐	Vaginal discharge or spurious bleeding	☐	☐
Chest pain	☐	☐	Difficulty with balance or locomotion; falls	☐	☐
Needs for more than one pillow for proper sleeping	☐	☐	Epilepsy or falling	☐	☐
			Circulation	☐	☐

If the answers to any of the above are 'YES", please give details:

_____

_____

_____

_____

5 MENTAL HEALTH

Mini-Mental Status Exam (if applicable) _____

_____

Behaviour: _____

_____

6 PHYSICAL EXAMINATION (check ✓)

BP _____ Pulse _____ Reg/Irreg _____

Height _____ ft _____ in Weight _____lbs. Overweight ☐ Under weight ☐ Normal ☐

EARS:	Yes	No	**CHEST:**	Yes	No
Is hearing obviously impaired	☐	☐	Does chest appear barrel sloped or otherwise abnormal	☐	☐
If any decrease in the hearing, is it due to:	☐	☐	Are either fine or coarse rales present		
Pathology in external auditory canal	☐	☐	in right base	☐	☐
Other causes	☐	☐	in left base	☐	☐
Is hearing aid being used	☐	☐	Is there evidence of consolidation or other abnormality in lungs	☐	☐
EYES:			**HEART:**		
Are eye glasses being worn	☐	☐	Blood pressure (mm. of Mercury) Systolic/Diastolic _____		
Is change of glasses or other visual aid needed to:			Pulse rate _____per minute		
Read a newspaper	☐	☐	Is there any irregularity of rhythm	☐	☐
Count fingers at 6 foot distance	☐	☐	Is apex beat lateral to mid clavicular line	☐	☐
Is applicant registered with the C.N.I.B. Note: A person with corrected vision of 20/200 or less may be so registered	☐	☐	Are any cardiac murmurs present	☐	☐

NOSE:	Yes	No
Are polyps or other nasal obstructions present	☐	☐
Is patient a mouth breather	☐	☐

TEETH:		
Are dentures, partial or complete, being worn	☐	☐
Do natural or artificial teeth need repair or replacement to permit proper mastication	☐	☐

NECK:		
Does the thyroid or other neck structure appear diseased or abnormal	☐	☐
Are the neck veins engorged when applicant sits	☐	☐

LOWER EXTREMITIES:		
Is there oedema of buttocks, if in bed; or ankles, if ambulatory	☐	☐
Is skin of legs abnormally coloured, shiny or abraded	☐	☐
Do the feet feel to be abnormally cold	☐	☐

ABDOMEN:	Yes	No
Is liver enlarged or tender	☐	☐
Are there any abnormal masses or tenderness	☐	☐
Is there any evidence of umbilical or inguinal hernia	☐	☐

GENITALIA:		
Is there any evidence of discharge or other abnormality	☐	☐

RECTUM:		
Is there any evidence of haemorrhoids or other pathology	☐	☐

SKIN:		
Any evidence of rashes, open sores, growths	☐	☐

If any of the above are answered "YES", please give details: _____

7 LABRATORY (most recent blood tests, x-rays and ECG results)

8 MEDICATION (please list all medications currently being taken)

9 DIET

Is it necessary for applicant to be on a special diet? ☐ Yes ☐ No

If so, please specify:

Any food allergies? ☐ Yes ☐ No

If so, please specify:

10 CONTAGIOUS OR COMMUNICABLE DISEASES

If applicant has a contagious or communicable disease, please give details:

11 ACTIVITY OF DAILY LIVING

	Independent	With help		Independent	With help
Feed self	☐	☐	Walk to bathroom	☐	☐
Sit in chair	☐	☐	Walk up and down stairs	☐	☐
Dress self	☐	☐	Walk to dining room for meals	☐	☐
Groom self	☐	☐	Leave residence unaccompanied	☐	☐
Bathe herself	☐	☐			

11 FURTHER COMMENTS AND RECOMMENDATIONS

Signature of professional completing form: _____

Position held

Telephone No.: _____

Name of current physician (if other than above): _____

Name of family physician (if other than above): _____

Does applicant have a doctor? ☐ Yes ☐ No ☐ Fulford Residence

Doctor's Name: _____

Eye Doctor: _____ *Telephone No.*

Dentist: _____ *Telephone No.*

Other medical specialists: _____ *Telephone No.*

_____ *Telephone No.*