Silverthorne Adult Medical Day Program
23 Geremonty Dr.
Salem, NH 03079 (603) 893-4799

HISTORY AND PHYSICAL EXAMINATION

Name:_____DOB_____

Diagnosis:_____

PMH:_____

_____Allergies:_____

BP:_____Pulse:_____Weight:_____Vision:_____Hearing:_____
Mental Status:_____ENT:_____Neck:_____

Chest:_____Abdomen:_____Breasts:_____Genitalia:_____

Musculoskelital:_____Neurological:_____

Skin:_____

Incontinence: Bladder Yes No Bowel: Yes No (Please Circle)

Recent tests or x-rays:_____

Rehabilitation
potential:_____

Medical Goals:_____

Are you aware of the patient having any type of advanced directive for health care?
_____yes_____no

I find no evidence of communicable disease in this patient at the time of this examination nor of any contraindication for participation in an Adult Day Care Program.

Date of last mantoux_____Result_____

MD signature_____Date_____

Printed name of MD_____