



**Dear Doctor**

This person is being assessed for admission/services within our organisation and any medical information you could provide on this form would be appreciated.

Form E

# MEDICAL HISTORY

Resident's Name: \_\_\_\_\_ Site: \_\_\_\_\_

Room #: \_\_\_\_\_  HC  LC UR #: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

<i>DETAILS</i>	<i>TYPE</i>	<i>DATE</i>
<input type="checkbox"/> Infectious and Parasitic Diseases	_____	_____
<input type="checkbox"/> Neoplasms, tumours or cancers	_____	_____
<input type="checkbox"/> Diseases of Blood and Immune mechanisms	_____	_____
<input type="checkbox"/> Endocrine, nutritional and metabolic disorders	_____	_____
<input type="checkbox"/> Mental and Behavioural disorders including dementia	_____	_____
<input type="checkbox"/> Psychoses and mood affective disorders	_____	_____
<input type="checkbox"/> Intellectual and development disorders	_____	_____
<input type="checkbox"/> Other mental and behavioural disorders	_____	_____
<input type="checkbox"/> Diseases of the nervous system	_____	_____
<input type="checkbox"/> Diseases of the eye and adnexa	_____	_____
<input type="checkbox"/> Diseases of the ear and mastoid process	_____	_____
<input type="checkbox"/> Diseases of the circulatory system	_____	_____
<input type="checkbox"/> Cerebrovascular disease	_____	_____
<input type="checkbox"/> Other diseases of the circulatory system	_____	_____
<input type="checkbox"/> Diseases of the respiratory system	_____	_____
<input type="checkbox"/> Diseases of the digestive system	_____	_____
<input type="checkbox"/> Muscular Skeletal	_____	_____
<input type="checkbox"/> Other	_____	_____

SURGICAL HISTORY

YEAR


ALLERGIES AND SENSITIVITIES


SUBSTANCE USE

Alcohol:  Yes  No

Use per day: \_\_\_\_\_

Smoking:  Yes  No

Use per day: \_\_\_\_\_

Other (Describe): \_\_\_\_\_

Use per day: \_\_\_\_\_

DOCTOR'S DETAILS

Are you the Applicant's usual Doctor?  Yes  No

If Yes, How Long Have You Known the Applicant? \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone (B): \_\_\_\_\_ Phone (A/H): \_\_\_\_\_ Mobile: \_\_\_\_\_

Signature: \_\_\_\_\_ Name: (please print) \_\_\_\_\_

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

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

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

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

