Healthcare Practitioner Form

Name: Mark Low	Gender: Male
Date of birth: 29/07/1984	Date: 12/02/2024
Emergency contact name: Marianne Low	
Emergency contact number: 027 364 98 28	
Emergency contact relationship: Wife	

Current medical and psychiatric history

Indicate recent changes in health or behavioral status, hospitalizations, suicide attempts, falls, etc, within 6 months.

Broke three ribs whilst mountain biking in November 2024, stilll some discomfort when lifting arms above head or lifting heavy objects

Medical history

Describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

Mild consistant back pain due to office job, gained 23kg in 2020 - lost about 10 but still working on it. Mild history of depression after both parents died in car crash when 18.

Allergies

List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem.

Gluten

Communicable diseases

Is the patient free from communicable TB and other active reportable airborne communicable disease(s)?

☑ Yes	☐ No

Indicate the disease:

List the tests done to verify the patient is free from active communicable disease

Chest X-ray for T, COVID-19 test

Drug abuse history		
Does the patient have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?		
Substance: OTC, non-prescription medication abuse or misuse	Recent (within 6 months):	☐ Yes ☑ No
	History:	☐ Yes ☑ No
Abuse or misuse of prescription medication or herbal supplements	Currently:	☐ Yes ☑ No
	Recent (within 6 months):	☐ Yes ☑ No
History of non-compliance with prescribed medication	Currently:	☐ Yes ☑ No
	Recent (within 6 months):	☐ Yes ☑ No
Describe misuse or abuse:		

Risk factors for falls and injuries	
Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply)	
☐ Osteoporosis	☐ Confusion
☐ Parkinsons	☐ Foot deformity
☐ Pain	☐ Orthostatic hypotension
☐ Gait problem	☐ Impaired balance
☐ Assistive devices	☐ Other (explain):

Skin conditions
Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders.
Chronic scabies aged 21/22

Sensory impairments affecting function (check all that apply):	
Left ear	☑ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid
Right ear	☐ Adequate ☑ Poor ☐ Deaf ☐ Uses corrective aid
Vision	☑ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind ☐ Left ☐ Right

Temperature sensitivity	☑ Normal
	Decreased sensation to: ☐ Heat ☐ Cold
Current nutritional status	
Height (inches): 5 11'	Weight (lbs): 230
Weight change (gain or loss) in the past 6 months	☑ Yes ☐ No
How much weight change?	4.4 lbs in the past 5 months
Is there evidence of malnutrition or risk for undernutrition?	☐ Yes ☑ No
Is there evidence of dehydration or a risk for dehydration?	☐ Yes ☑ No
Any medical or dental conditions affecting: (Check all that apply)	☐ Chewing ☐ Swallowing ☐ Eating ☐ Pocketing food ☐ Tube feeding
Medications	
Include dosage route, frequency, duration	What diagnoses are currently being treated by this medication?
n/a	n/a
Prescriber signature: n/a	Date: n/a
Phone: n/a	Address: n/a
Signatures	
Patient: M.Low	Date: 12/02/2024
Healthcare provider: L.T Healthcare	Date: 12/02/2024

Adapted from

Maryland Department of Health. (n.d). *Health care practitioner physical assessment form*.https://health.maryland.gov/ohcq/docs/AL%20Forms/hcppa.pdf?csf=1&e=nksaYx