



68 Hauppauge Road, Commack, NY 11725  
 631-715-2520 Fax: 631-715-2915

**MEDICAL HISTORY**

PARTICIPANT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AMB. STATUS: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

BP: \_\_\_\_\_ ALLERGIES: Medication \_\_\_\_\_ Food \_\_\_\_\_

Physical Exam: (Please identify – Public Health Regulations prohibit the use of check marks):

SKELETON	_____	GLANDS	_____
EYES	_____	SKIN	_____
SINUSES	_____	FUNDI	_____
TEETH	_____	NOSE	_____
NECK	_____	MOUTH	_____
CHEST	_____	THROAT	_____
LUNGS	_____	THYROID	_____
HEART	_____	BREASTS	_____
ABDOMEN	_____	RECTAL	_____
GENITALIA	_____	PELVIC	_____
NEUROLOGICAL	_____	EXTREMETIES	_____

MEDICAL DIAGNOSIS (INCL. ICD- 10 CODES): \_\_\_\_\_

PYSCHIATRIC/OTHER DX: \_\_\_\_\_

DIET (required): \_\_\_\_\_

SURGERY: \_\_\_\_\_

FUNCTIONAL LIMITATION, SPECIAL PRECAUTIONS TO BE OBSERVED: \_\_\_\_\_

HOSPITAL ADMISSIONS: \_\_\_\_\_ DISCHARGE DATE: \_\_\_\_\_

<p><b>**REQUIRED FOR PROGRAM**</b></p>
<p>PPD Date: _____</p> <p>Pos: _____ Neg: _____</p> <p>If positive, chest x-ray/Quantiferon Gold Result: _____</p> <p>Date: _____</p> <p>*****</p> <p>Pneumovax given</p> <p>Yes: ___ No: ___</p> <p>If Yes, Date: _____</p> <p>*****</p> <p>COVID VACCINE: Yes: ___ No: ___ TYPE: _____ Date: _____</p>

