Medical History and Medical Clearance Form

Form Must Be Completed by Applicant's Physician and Included with the Housing Application

Doctor's Name: _____

Date: _____

Address: _____

Phone Number: _____ Fax: _____

Patient's Name: _____ Date of Birth: _____

Gender: _____ Height: _____ Weight: _____

Please check all that apply.

Does the patient have a history of:

- ☐ **Asthma**
- ☐ **Cancer**
- ☐ **Cardiac disease**
- ☐ **Diabetes**
- ☐ **Hypertension**
- ☐ **Epilepsy**
- ☐ **Psychiatric disorder**

Check the symptoms that patient is currently experiencing, if any:

- ☐ **Chest pain**
- ☐ **Respiratory**
- ☐ **Cardiac disease**
- ☐ **Cardiovascular**
- ☐ **Hematological**
- ☐ **Lymphatic**
- ☐ **Neurological**
- ☐ **Psychiatric**
- ☐ **Gastrointestinal**
- ☐ **Genitourinary**
- ☐ **Weight gain**
- ☐ **Weight loss**
- ☐ **Musculoskeletal**

Does the patient have any medication allergies? ☐ **Yes** ☐ **No**

Has the patient had the Hepatitis B vaccination? ☐ **Yes** ☐ **No**

Has the patient had the COVID-19 vaccination? ☐ **Yes** ☐ **No**

Immunity information (please note: this information must be provided prior acceptance)

Chicken Pox (Varicella): ☐ IMMUNE ☐ NOT IMMUNE

Measles: ☐ IMMUNE ☐ NOT IMMUNE

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List any Allergies:

The Joan Valentine House is a licensed residential healthcare facility and cannot provide the level of care provided by a nursing home.

Agnie's House is a supportive apartment program and does not provide the level of service of a Residential Healthcare Facility.

Please provide the following:

Criteria	Yes	No*
Patient is able to ambulate without assistance		
Patient is free of communicable diseases		
Patient is clear of any lice/nits and has been examined		
Patient is capable of taking care of his/her own hygiene		
Patient is capable of doing his/her own laundry		
Patient is able to climb 16 stairs unassisted		
If applicable: Patient can check his own blood glucose level and administer insulin		

Please provide explanation for any criteria marked no:

Must be completed and signed by the physician.

This is to certify that I Doctor _____

have examined, _____ and completed the medical clearance form on

(Date): _____.

Doctor's Signature: _____