



# Friendly Towers

## APPLICANT HEALTH HISTORY

**\*\*TO BE COMPLETED BY APPLICANT'S PRIMARY PHYSICIAN or D.O.N.\*\***

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Please list physicians/surgeons patient has seen in the past five years (begin with primary physician completing this form):

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Clinic or Hospital: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Clinic or Hospital: \_\_\_\_\_

Does patient have any allergies?

No \_\_\_\_\_ Yes (Specify) \_\_\_\_\_

Illnesses:

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_

2. \_\_\_\_\_ Date of onset: \_\_\_\_\_

Surgeries:

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

Has patient ever been under the care of a psychologist or psychiatrist, or been hospitalized for a nervous disorder?

No \_\_\_\_\_ Yes (where and when) \_\_\_\_\_

Medications:

Name: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Does patient take medicines: (Circle One)**

- (a) Without help and without difficulty
- (b) Without help but with difficulty
- (c) With help (someone to prepare or remind)
- (d) Cannot self-administer

**Does patient smoke:** No \_\_\_\_\_ Yes (how much): \_\_\_\_\_

**How much alcohol does patient usually drink each day? (Circle One)**

- (a) None
- (b) Occasional or social
- (c) 1 drink per day
- (d) 2 drinks per day
- (e) 3 drinks per day
- (f) do not know

**Does patient use any of the following items to assist mobility?**

- (a) None
- (b) Cane
- (c) Prong Cane
- (d) Walker
- (e) Prosthesis
- (f) Crutches
- (g) Wheelchair
- (h) Other (specify) \_\_\_\_\_

**Is patient able to climb stairs without difficulty?**

Yes \_\_\_\_\_ No (specify difficulty) \_\_\_\_\_

**How far can patient walk before getting tired?**

- (a) Less than 1 block
- (b) 1-2 blocks
- (c) 3-4 blocks
- (d) Over 4 blocks

**Is patient able to get in and out of bathtub without difficulty or help?**

Yes \_\_\_\_\_ No (specify difficulty) \_\_\_\_\_

**Is patient fully continent?**

Yes \_\_\_\_\_ No (specify nature/degree) \_\_\_\_\_

**If difficulty with continence, does patient wear protective devices?**

Yes \_\_\_\_\_ No (specify why not) \_\_\_\_\_

**Is patient able to manage own hygiene?**

Yes \_\_\_\_\_ No (specify why not) \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF PRIMARY PHYSICIAN**

\_\_\_\_\_  
**Office Phone Number**