Louis and Anne Green
Memory and Wellness Center
Christine E. Lynn College of Nursing
777 Glades Road Bldg. AZ 79
Boca Raton, FL 33431
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memorylane@fau.edu
www.fau.edu/ memorywellnesscenter

MEDICAL INFORMATION

Participant's Name_____ Date of birth _____

Please check if there is the presence or a history of:

- ❑ Allergies (please specify)
- ❑ Alzheimer's
- ❑ Asthma
- ❑ Amputation
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Atrial Fibrillation
- ❑ Back injury
- ❑ Blindness
- ❑ Bowel Problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chest Pain
- ❑ Congestive Heart Failure
- ❑ Decreased sensation
- ❑ Dementia
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticulitis
- ❑ Edema
- ❑ Emphysema
- ❑ Fainting Spells
- ❑ Falling
- ❑ Fractures
- ❑ Glaucoma
- ❑ Hearing Aids
- ❑ Heart Attack
- ❑ Heart Murmurs
- ❑ Hernias
- ❑ Hypertension
- ❑ Insomnia
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Palpitations
- ❑ Paralysis
- ❑ Parkinson's Disease
- ❑ Pneumonia
- ❑ Peripheral Vascular Dis
- ❑ Restless Legs
- ❑ Seizures
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Swallowing Problems
- ❑ Thyroid Disease
- ❑ Tran ischemic Attack
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Urinary Problems
- ❑ Vertigo
- ❑ Other_____
- ❑ Other_____

List of Past Surgeries: _____

_____

Medications: **Dosage:** **Frequency:** **Discontinue:**

_____

_____

_____

_____

Participant's Name_____ Date of birth _____

Allergies:

Medication:_____

Food: _____

Type of Diet:_____Dietary restrictions:_____

Mobility Restrictions:_____

Vital signs: B/P_____P-AP_____RP_____

Can Tylenol be given as needed? (circle one) Yes No

I also certify this participant is physically able to participate in the Center's activities and exercise programs.

Physician Signature_____ Date_____

Name of Physician_____

Mailing Address _____

Physician Telephone (_____)_____ Fax (_____)_____

(For initial enrollment this statement must be completed within 45 days prior to the admission to the Center.)

TB/Communicable Disease Statement

As a Florida licensed healthcare provider, I certify that this individual is free of tuberculosis in its communicable form and does not exhibit signs and symptoms of other communicable diseases.

_____ _____

Patient Name Date of Birth

Date of last PPD test _____ Results of test _____

Date of last chest x-ray _____ Results of test _____

Physician Signature_____ Date_____

Name of Physician_____

Mailing Address _____

Physician Telephone (_____)_____ Fax (_____)_____

(For initial enrollment this statement must be completed within 45 days prior to the admission to the Center.)