Homer Senior Citizens, Inc.

3935 Svedlund Street
Homer, Alaska 99603
(907) 235-7655 Fax: (907) 235-3739

PHYSICIAN AUTHORIZATION FORM

Patient Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____

Date of Last Exam: _____

Height: _____ Weight: _____ Pulse: _____ BP _____

Medical Conditions: _____

_____

Medications: _____

Allergies, Special Considerations: _____

_____

_____ Yes my patient can participate.

_____ No my patient cannot participate.

Physician's Signature: _____

Print Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Medical History and Current Health Survey

Name: _____

Please read the following carefully and circle Yes or No as it applies to your medical history and current health. Please include any additional information and conditions for which you are receiving medical care.

Medical History		
Aneurysm	Yes	No
Arthritis (Rheumatoid or Osteoarthritis)	Yes	No
Asthma	Yes	No
Back Pain	Yes	No
High Blood Pressure last reading	Yes	No
Low Blood Pressure last reading	Yes	No
Bone Fractures	Yes	No
Cancer (Please provide type & treatment)	Yes	No
High Cholesterol last reading	Yes	No
Diabetes Type I or Type II	Yes	No
Emphysema	Yes	No
Epilepsy	Yes	No
Family history of Heart Disease (Mother, Father, Siblings, Other)	Yes	No
Hernia	Yes	No
Joint or Ligament Injuries (Please specify)	Yes	No
Muscle Injuries (Please specify)	Yes	No
Neck Pain or Injury	Yes	No
Osteoporosis	Yes	No
Surgery	Yes	No
Terminal Illness	Yes	No
Vertigo or Lightheadedness	Yes	No
Other (Please specify)	Yes	No

Current Health—past month		
Back Pain	Yes	No
Chest Pain or Tightness	Yes	No
Discomfort from Waist up	Yes	No
Heart Palpitations	Yes	No
Indigestion	Yes	No
Jaw Pain	Yes	No
Joint Pain	Yes	No
Lightheadedness	Yes	No
Muscle Pain	Yes	No
Nausea	Yes	No
Neck Pain	Yes	No
New Medication or dosage changes	Yes	No
Shortness of breath	Yes	No
Other:	Yes	No

Signature: _____ Date: _____