LIBERTY HOUSE FOUNDATION, INC.
54 Bay Street
Glens Falls, NY 12801

MEDICAL ASSESSMENT FORM

(Please complete and return to Liberty House Foundation, Inc. at the above address or fax to (518) 798-1166.)

PATIENT NAME: ___________________________ DATE OF BIRTH: ___________________ AGE: ________

MEDICATIONS: ____

GENERAL APPEARANCE: ____

HEIGHT: ___________________________________ WEIGHT: ___________________________________

SKIN: _____________________________________ HAIR & SCALP: _____________________________

HEART: ____________________________________ BLOOD PRESSURE: ___________________________

PULSE: ____________________________________ MOUTH/TEETH/GUMS: _________________________

LUNGS: ____________________________________ GLANDS: __________________________________

ABDOMEN: __________________________________ HERNIA: __________________________________

BACK & SPINE: _____________________________ FEET: ____________________________________

EXTREMITIES: ______________________________ REFLEXES: ________________________________

GENITALIA: ________________________________ RECTAL: __________________________________

URINALYSIS: _______________________________

*** REQUIRED***
TB TEST DATE: _________________
RESULT: ________________________

ILLNESSES, DISEASES, INJURIES, DEFORMITIES (EXPLAIN): ____

____

ANY KNOWN ALLERGIES? ____

____

CONTRAINDICATORS TO EMPLOYMENT? ____

____

PHYSICIAN SIGNATURE: ____ **DATE:** __________________

PRINT OR TYPE NAME: ____

CONSENT: I hereby give my consent to release information from my records to Liberty House Foundation, Inc.

PATIENT SIGNATURE: ____ **DATE:** __________________

Revised: 06/02/16