

SELF-STATED PERSONAL HEALTH HISTORY

History and Physical (H&P) documentation must be obtained from your physician and included with your application. The application is considered incomplete without the H&P information.

APPLICANT INFORMATION

1. Applicant Name _____

2. Estimate, in your own words, the condition of your health. _____

3. Please list your current: Age _____ Weight _____ Height _____

4. Do you or have you ever had any of the following? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Failure/Dialysis | <input type="checkbox"/> Glaucoma or Macular Degeneration |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Incontinence of Bowel or Bladder |
| <input type="checkbox"/> Substance Abuse/Alcoholism | <input type="checkbox"/> Parkinson's or Other
Neurological Disorders | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Heart Disease or
History of Heart Attack | <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Circulatory Problems or
Swelling in Feet or Legs |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Difficulty Ambulating | |

Have you ever been hospitalized for any of the above? If so, please describe. _____

5. Do you use any of the following equipment?

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Power Chair/Scooter | <input type="checkbox"/> In Home Dialysis Equipment |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Feeding Tube |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Hoyer Lift | |

6. Describe in detail any mental illnesses, memory loss or substance abuse/alcoholism you have experienced. Please specify diagnosis, date of onset, and current status.

7. Do you smoke? Yes No

Twin Lakes Community is a tobacco-free community. Use of tobacco products is strictly prohibited.

8. Describe any past surgical operations, serious illnesses or hospitalizations not previously mentioned. Please give dates and details. _____

9. Please describe any mobility limitations. _____

10. Do you require any assistance with:

Dressing Bathing Ambulating/Walking Meal Preparation Taking Medications

11. Do you drive? Yes No

12. Do you live independently? Yes No If no, please describe current arrangements. _____

13. Please list your current primary care physician.

Name _____

Address _____

Phone _____

14. Do you see any specialty physicians? Please check all that apply.

Neurologist Psychotherapist/Psychiatrist Cardiologist Other

What conditions are you seeing these specialists for? _____

15. What are your current medications? _____

16. What medications, not listed in number 15, have you taken in the last year? _____

17. Please list any other pertinent health history or diagnosis not mentioned above. _____

18. Do you have any medical/personal care services you would be anticipating Twin Lakes Community to provide upon residency? If so, please describe. _____

The medical and personal information submitted by the applicant within this self-stated personal health history is a material part for determination of a contract agreement. Any misrepresentation or omissions are considered a breach of contract, permitting the contract to be declared null and void.

Date _____ Applicant Signature _____