

# MEDICAL EVALUATION

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

Address \_\_\_\_\_  
\_\_\_\_\_

M or F (circle) \_\_\_\_\_ Date of birth \_\_\_\_\_

Date of examination \_\_\_\_\_

Physical or mental limitations? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special diet? \_\_\_\_\_  
\_\_\_\_\_

Activity restrictions? \_\_\_\_\_  
\_\_\_\_\_

Is this individual capable of administering his/her own medication? \_\_\_\_\_

Is he/she ambulatory without assistance? \_\_\_\_\_

Is he/she incontinent? \_\_\_\_\_ Please clarify \_\_\_\_\_  
\_\_\_\_\_

Is he/she addicted to alcohol, tobacco, or any other harmful substance? \_\_\_\_\_

In your opinion is this individual capable of functioning independently in a retirement home which does not provide medical or nursing care? \_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (Print) \_\_\_\_\_

**Louis F. Payn  
FOUNDATION**



Retirement Residence

12 Coleman Street  
Chatham, NY 12037  
TEL 518-392-4971  
www.paynhome.org  
info@paynhome.org