PREADMISSION HISTORY AND PHYSICAL

Tenant Name_____ Birthdate:_____ Age:_____

Address:_____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ Sep ☐ W

Guardian/Resident Representative_____ Relationship_____

Address:_____Phone:_____

MEDICAL HISTORY/DISEASES

Check all that apply

ENDOCRINE/METOBOLIC/NUTRITIONAL

- ☐ Diabetes Mellitus
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

HEART/CIRCULATION

- ☐ Arteriosclerotic Heart Disease
- ☐ Cardiac Dysrhythmia
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Hypotension
- ☐ Peripheral Vascular Disease
- ☐ Other Cardiovascular Disease

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Hip Fracture
- ☐ Missing Limb (e.g. ,amputation)
- ☐ Osteoporosis
- ☐ Pathological Bone Fracture

NEUROLOGICAL

- ☐ Alzheimer's
- ☐ Aphasia
- ☐ Cerebral Palsy
- ☐ Cerebrovascular Accident
- ☐ Dementia other than Alzheimer's
- ☐ Hemiplegia/Hemiparesis
- ☐ Multiple sclerosis
- ☐ Paraplegia
- ☐ Parkinson's Disease
- ☐ Quadriplegia
- ☐ Seizure Disorder
- ☐ Transient Ischemic Attack (TIA)
- ☐ Traumatic Brain Injury

PSYCHIATRIC/MOOD

- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Manic Depression (Bipolar Disease)
- ☐ Schizophrenia

PULMONARY

- ☐ Asthma
- ☐ Emphysema/COPD

SENSORY

- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration

OTHER

- ☐ Allergies
- ☐ Anemia
- ☐ Cancer
- ☐ Renal Failure

INFECTIONS

Check all that apply

- ☐ Antibiotic Resistant Infection
- ☐ Clostridium Difficile
- ☐ Conjunctivitis
- ☐ HIV Infection
- ☐ Pneumonia
- ☐ Respiratory Infection
- ☐ Septicemia
- ☐ Sexually Transmitted Diseases
- ☐ Tuberculosis
- ☐ Urinary Tract Infection in last 30 days
- ☐ Viral Hepatitis
- ☐ Wound Infection

LAB/TEST RESULTS

Urinalysis: Results: _____ Date Done: _____

CBC Results: _____ Date Done: _____

Last T.Toxoid Results: _____ Date Done: _____

Chest X-Ray Results: _____ Date Done: _____

IMMUNIZATION/VACCINATION RECORD

☐ Influenza; Date_____

☐ Pneumonia; Date_____

☐ Tetanus; Date_____

☐ Shingles; Date_____

_____

To my knowledge this resident is free of any clinically apparent communicable disease.

☐ Yes ☐ No

PHYSICAL EXAM

Height:_____ Weight:_____ B/P:_____ Temp:_____ Pulse:_____ Resp:_____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____ Oral Exam: _____

Neck: _____ Heart: _____ Lungs: _____ Abdomen: _____ Genetalia: _____

Rectal: _____ Back: _____ Extremities: _____ Skin: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____