DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

# RESIDENT ADMISSION MEDICAL AND PERSONAL HISTORY

Name: _____ Date of Birth: _____

Address: _____
Number Street City Island Zip Code

Resident's pertinent past history:

_____

_____

Height: _____ Weight: _____ B/P: _____

_____

**Level of Care Assessment:**
The Resident is certified as: ☐ **Independent** ☐ **ARCH** ☐ **ICF** ☐ **SNF**

_____ _____

Presents no symptoms, such as skin lesions, respiratory tract symptoms, diarrhea, or other symptoms to indicate the presence of infectious diseases which may harm others. Yes ☐ No ☐

Vision impairment? Yes ☐ No ☐

Hearing impairment? Yes ☐ No ☐

Prescription glasses? Yes ☐ No ☐

Hearing aid? Yes ☐ No ☐

Allergies: _____ Teeth _____ Mouth _____ Throat _____

Circulation/Heart: _____

Respiratory System: _____

GI System: _____

Urinary System: _____

Nervous System: _____

Extremities: arms _____ legs _____

Skin: _____

Diagnoses:

_____

Medications:

Diet:

Activities/therapy program:

History of chronic mental illness: Yes ☐ No ☐

If "yes", explain:

Is resident being treated for chronic mental illness? Yes ☐ No ☐

Psychiatric follow-up due

Psychiatrist Phone:

Medical follow-up due

Physician Phone:

Any history of violent, destructive behavior to persons or property, or wandering behaviors:

Behavioral modification advised:

Patient is physically and mentally capable of following directions and taking appropriate action for self-preservation in the event of fire or other emergency: Yes ☐ No ☐

Immunization history:

Tetanus-diphtheria-toxoid (Booster every 10 years)

Pneumococcal vaccine (over 65 years 1x and as needed)

Influenza vaccine (over 65 years annually)

Physician/APRN Signature | Date | Phone Number

Print or Type Physician/APRN Name