HALE NOHEA
Maunalani

Resident Physical Examination Record

Name:____ **Birth Date**:______________________

Height:_______ **Weight:** _______ **Temp:** _______ **HR:** _______ **RR:** _______ **BP:** _______ **O2:** _______

General: ____

Head: ____

Ears: ____

Eyes: ____

Nose: ____

Mouth/Neck: ____

Heart/CVS: ____

Lungs: ____

Abdomen: ____

Genitalia/Pelvis: ____

Back: ____

Lymph: ____

MSK/Exetremities: ____

Skin: ____

Neuro: ____

Mental Status/Psych: ____

Current medications, or attach list:____

____

Resident is ambulatory: ___**Yes** ___**No**

Resident is capable of following directions and taking appropriate action for self preservation under emergency conditions: ___**Yes** ___**No**

Diagnosis:____

____

____

Diet Orders:____

Level of Care Assessment:

The Resident is certified as: ___**Independent** ___**ARCH** ___**ICF** ___**SNF**

______________________________	______________________________	______________________
Print or type physician's name	Physician's Signature	Date

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