HALE NOHEA

Maunalani

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:

Resident is certified as: Independent ARCH ICF SNF

Presents no symptoms, such as skin lesion, respiratory tract symptoms, diarrhea, or other symptoms to indicate the presence of infections 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:____

Diagnois:____

____

____

Medications:____

____

____

Diet:____

Activities/therapy program:____

History of chronic mental illness: Yes No

If "yes", explain:____

Is the 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:

____

Is 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