MEDICAL HISTORY/PHYSICAL/FUNCTIONAL ASSESSMENT

SECTION 1 - TO BE COMPLETED BY RESIDENT OR FAMILY

PERTINENT BACKGROUND INFORMATION

Physician_____

Recent hospitalization ❍ No ❍ Yes Dates_____ — _____

Reason_____

Diagnosis(es)/Condition(s)

Other prior hospitalization(s)? ❍ No ❍ Yes, how many times:_____

Reason(s)/When

COMMUNICATION

Methods of Communication:

❑ Verbal ❑ Written ❑ Signs ❑ Gestures
❑ Reads lips ❑ Reads Braille ❑ VOCA
❑ Communication board ❑ AAC device
❑ Other, specify

Primary Language _____

❑ Difficulty understanding English
❑ Needs interpreter
❑ Hard of hearing

LEVEL OF FUNCTIONING – ACTIVITIES OF DAILY LIVING

(Functional Levels: I - Totally Independent; A - Needs Assistance; D - Dependent)

ACTIVITY	I	A	D	COMMENTS (assistive devices used)
Eating	❍	❍	❍	
Transfer	❍	❍	❍	
Dressing/Grooming	❍	❍	❍	
Bathing	❍	❍	❍	
Toileting	❍	❍	❍	
Ambulation	❍	❍	❍	
Communication	❍	❍	❍	
Preparing light meals	❍	❍	❍	
Preparing full meals	❍	❍	❍	
Light housekeeping	❍	❍	❍	
Personal laundry	❍	❍	❍	
Shopping	❍	❍	❍	
Transportation	❍	❍	❍	
Handling money	❍	❍	❍	
Using telephone	❍	❍	❍	
Reading	❍	❍	❍	
Writing	❍	❍	❍	
Managing medications	❍	❍	❍	
Other (Specify)	❍	❍	❍	

APPLIANCES / AIDS / EQUIPMENT

❑ Cane ❑ Walker ❑ Crutches
❑ Wheelchair ❑ Scooter
❑ Brace ❑ Orthotic (specify)

❑ Bedside commode ❑ Urinal
❑ Prosthesis
❑ Right arm/hand ❑ Left arm/hand
❑ Right leg/foot ❑ Left leg/foot
❑ Other_____
❑ Oxygen: Leasing co._____
Leasing co. phone_____
Frequency of use_____
❑ Other equipment
_____
❑ Own ❑ Lease
Leasing co._____
Leasing co. phone_____

SECTION 2 - TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

EYES/EARS

EYES

❑ Glasses ❑ Glaucoma ❑ Jaundice ❑ Contacts: ❑ R ❑ L
❑ Blurred vision ❑ Ptosis ❑ Prosthesis: ❑ R ❑ L ❑ Legally blind
❑ PERRLA: ❍ Yes ❍ No _____ ❑ Infections_____
❑ Cataract surgery: Date_____
❑ Other, specify hx_____

❑ NO PROBLEM

EARS

❑ HoH: ❑ R ❑ L ❑ Deaf: ❑ R ❑ L ❑ Hearing aid: ❑ R ❑ L
❑ Vertigo ❑ Tinnitus ❑ Cerumen ❑ Other, specify hx

❑ NO PROBLEM

HEAD/NECK

❑ Headache (❑ see Neurological section)
❑ Injuries/Wounds (❑ see Skin Condition/Wound section)
❑ Masses/Nodes: Site_____ Size_____
❑ Alopecia_____
❑ Other, specify hx

❑ NO PROBLEM

VITALS/ALLERGIES

T°_____ ❑ O ❑ T ❑ Ax Ht._____ Wt._____
Resp._____ ❍ Reg. ❍ Irreg.
Pulse: A _____ R _____ F _____ ❍ Reg. ❍ Irreg.

BP	LYING	SITTING	STANDING
RIGHT			
LEFT			

Allergies: ❍ None Known ❑ Aspirin ❑ Sulfa ❑ Penicillin ❑ Pollen
❑ Eggs ❑ Milk Products ❑ Insect Bites ❑ Other_____

NOSE/THROAT/MOUTH

NOSE

❑ Congestion ❑ Epistaxis
❑ Loss of smell ❑ Sinus prob.
❑ Other, specify hx
_____

❑ NO PROBLEM

THROAT

❑ Dysphagia ❑ Hoarseness
❑ Lesions ❑ Sore throat
❑ Other, specify hx
_____

❑ NO PROBLEM

MOUTH

❑ Dentures: ❑ Upper ❑ Lower ❑ Partial ❑ Masses/Tumors
❑ Gingivitis ❑ Ulcerations ❑ Toothache ❑ Implant(s): ❑ Upper ❑ Lower
❑ Bridge: ❑ Removable ❑ Permanent
❑ Other, specify hx _____

❑ NO PROBLEM

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

ENDOCRINE

❑ Enlarged thyroid ❑ Fatigue ❑ Intolerance to heat/cold
❑ Diabetes: ❍ Type 1 ❍ Type 2 Onset Date _____
❑ Diet/oral control X_____ ❍ months ❍ years
❑ Med/dose/freq._____
❑ Insulin/dose/freq. _____
❑ Hyperglycemia: ❑ Glycosuria ❑ Polyuria ❑ Polydipsia
❑ Hypoglycemia: ❑ Sweats ❑ Polyphagia ❑ Weak ❑ Faint ❑ Stupor
❑ Blood glucose range _____ Normal _____
❑ Self-care/Self-observational tasks, specify

❑ Other, specify hx_____

❑ **NO PROBLEM**

GASTROINTESTINAL

Nutritional requirements (diet)
_____
❍ Increase fluids _____ amt. ❍ Restrict fluids _____ amt.
Appetite: ❍ Good ❍ Fair ❍ Poor ❍ Anorexic
Eating patterns_____
Swallowing problems ❍ No ❍ Yes _____
❑ Nausea/Vomiting: ❑ Blood ❑ Bile ❑ Other_____
Freq. _____ Amt. _____
❑ Heartburn (food intolerance)
Date of Last BM _____ Usual frequency_____
❑ Diarrhea: ❑ Less than 3x/day ❑ Greater than 3x/day
❑ Mucus ❑ Pain ❑ Foul odor ❑ Frothy Amount _____
❑ Abnormal stools: ❑ Gray ❑ Tarry ❑ Fresh blood
❑ Constipation: ❑ Chronic ❑ Acute ❑ Occasional
❑ Lax./Enema use: Type_____ Freq._____
❑ Hemorrhoids: ❑ Internal ❑ External ❑ Painful
❑ Rx (specify) _____
❑ Flatulence: Freq. _____
❑ Impaction ❑ Incontinent of stool: Freq. _____
❑ Abdominal distention: ❑ Cramping ❑ Pain Freq._____
❑ Ascites: Girth_____ inches ❑ Firm ❑ Tender
Bowel sounds: ❑ Active ❑ Hyperactive X_____ quads
❑ Absent X_____ quads ❑ Rebound ❑ Hot ❑ Red ❑ Discolored
❑ Colostomy: ❑ Sigmoid ❑ Transverse Date _____
❑ Weight change: ❍ Gain ❍ Loss _____lb. X_____ ❍ wk ❍ mo ❍ yr
❑ Other, specify hx_____

❑ **NO PROBLEM**

GENITOURINARY

Urine: Color_____ Amt._____ Odor: ❍ No ❍ Yes
❑ Incontinence: ❑ Stress ❑ Urgency ❑ Spasms
Freq._____ Rx_____
❑ Hematuria ❑ Polyuria ❑ Oliguria ❑ Burning
❑ Retention: ❑ Cramping ❑ Dysuria ❑ Sediment
❑ Anuria ❑ ESRD, Diagnosis Date_____
Nocturia X_____ Rx_____
❑ Ileostomy ❑ Ileal Conduit Date_____
Appliance_____
Irrigation: ❍ No ❍ Yes Freq._____ Sol._____ Amt._____
❑ Indwelling cath.: Size_____ _____ cc balloon
Last date changed_____ Freq. of change_____
❑ External catheter: Type/brand_____
❑ Other, specify hx_____

❑ **NO PROBLEM**

GENITAL SYSTEMS

Discharge/Drainage: ❑ Urine ❑ Vaginal mucus ❑ Feces
❑ Lesions ❑ Blisters ❑ Masses ❑ Cysts _____
Inflammation _____
Surgical alteration _____
Prostate problem: ❑ BPH ❑ TURP Date _____
Self-testicular exam: Freq. _____
Menopause: ❑ Hysterectomy Date _____
Date last PAP _____ Results _____
❑ Breast self-exam. freq. _____ ❑ Discharge: ❑ R ❑ L
Date last mammogram _____ Results _____
❑ Mastectomy: ❑ R ❑ L Date _____
❑ Other, specify hx_____

❑ **NO PROBLEM**

HEMATOLOGY

❑ Anemia: ❑ Iron deficient ❑ Pernicious ❑ Other_____
❑ 2° Bleed: ❑ GI ❑ GU ❑ GYN ❑ Unknown ❑ Other_____
❑ Thrombocytopenia ❑ Coagulation disorders
❑ Hemophilia, other _____
❑ Malignancies specify_____
Prior Rx _____
Complications_____
❑ Other, specify hx_____

❑ **NO PROBLEM**

NEUROLOGICAL

❑ Oriented X_____ ❑ Disoriented ❑ Lethargic ❑ Agitated
❑ Comatose ❑ Forgetful ❑ Slurred speech
❑ Insomnia/Change in sleep pattern ❑ Syncope ❑ Vertigo
❑ Sensory loss ❑ Ataxia ❑ Neuropathy ❑ Hx of frequent falls
❑ Numbness ❑ Impaired decision-making ability
❑ Memory loss: ❑ Short term ❑ Long term
❑ Headache: Loc. _____ Freq. _____
❑ Aphasia: ❑ Receptive ❑ Expressive
❑ Motor change: ❑ Fine ❑ Gross
❑ Weakness: ❑ UE ❑ LE Location_____
❑ Tremors: ❑ Fine ❑ Gross ❑ Paralysis
❑ Stuporous ❑ Hallucinations: ❑ Visual ❑ Auditory ❑ Delusions
❑ Unequal pupils: ❑ R ❑ L ❍ PERRLA
Hand grips: ❑ Equal ❑ Unequal, specify_____
❑ Strong ❑ Weak, specify_____
❑ Psychotropic drug use (specify) _____
Dose/Freq._____
❑ Other, specify hx_____

❑ **NO PROBLEM**

PSYCHOSOCIAL

❑ Angry ❑ Discouraged ❑ Flat affect ❑ Withdrawn ❑ Disorganized
❑ Difficulty coping ❑ Combative ❑ Suicidal: ❑ Ideation ❑ Verbalized
❑ Dementia, Diagnosis Date_____
Plan_____
❑ Depressed: ❑ Recent ❑ Long term Rx_____
Due to: ❑ Lack of motivation ❑ Unrealistic expectations
❑ Inability to recognize problems ❑ Denial of problems
❑ Other, specify_____
❑ Inappropriate responses to caregivers/clinician
❑ Inappropriate follow-through in past
❑ Invested in "sick role"
❑ Substance use: ❑ Drugs ❑ Alcohol ❑ Tobacco ❑ Other_____
❑ Other, specify hx_____

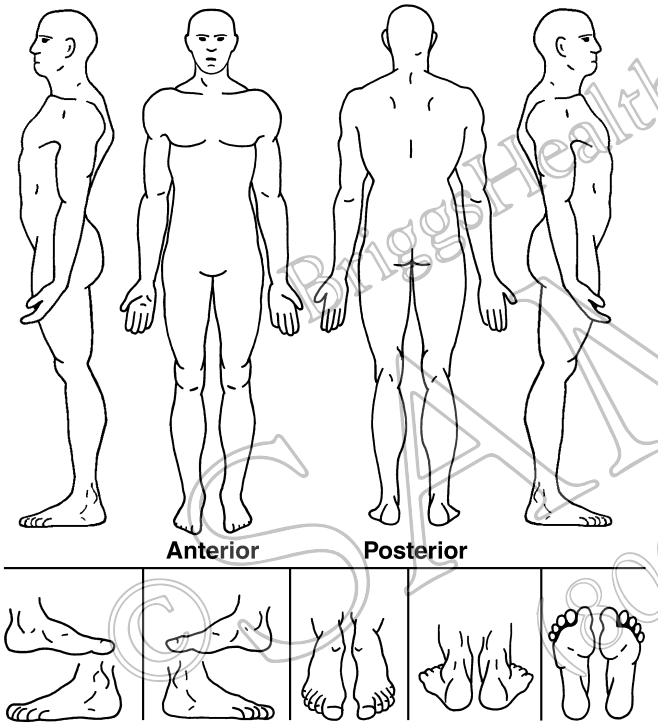
❑ **NO PROBLEM**

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

SKIN CONDITION/WOUNDS

❑ Itchy ❑ Rash ❑ Dry ❑ Scaling ❑ Incision ❑ Wounds ❑ Lesions
❑ Pressure injuries ❑ Fistulas ❑ Abrasions ❑ Lacerations ❑ Bruises
❑ Ecchymosis ❑ Sutures ❑ Staples ❑ Pallor ❑ Jaundice ❑ Redness
Turgor: ❍ Good ❍ Poor
Edema: ❑ No edema ❑ 1+ ❑ 2+ ❑ Pitting ❑ RLE ❑ LLE
Other, specify hx

❑ **NO PROBLEM**



Identify location of specific skin condition/wounds. Proceed by completing applicable information for each site on chart.

CONDITION	#1	#2	#3	#4
Location				
Size (cm)				
Depth				
Stage				
Drainage/Amt.				
Tunnelling				
Odor				
Sur. tissue				
Edema				
Stoma				

PAIN

Origin_____ Onset_____
Location

Quality (i.e., burning, dull ache, etc.) _____
Intensity level (specify)_____
Frequency/Duration

Relieved by

Other, specify

❑ **NO PROBLEM**

MUSCULOSKELETAL

❑ Fracture (location)_____
❑ Swollen, painful joints (specify)_____
❑ Contractures: Joint _____ Location _____
❑ Atrophy ❑ Poor conditioning
❑ Decreased ROM _____ ❑ Paresthesia _____
❑ Shuffling/Wide-based gait ❑ Weakness
❑ Amputation: ❑ BK ❑ AK ❑ UE ❑ R ❑ L specify_____
❑ Hemiplegia ❑ Paraplegia ❑ Quadriplegia
❑ Other, specify hx

❑ **NO PROBLEM**

FUNCTIONAL LIMITATIONS

❑ Dyspnea with minimal exertion
❑ Dyspnea when laying flat
❑ Bowel/Bladder incontinence
❑ Contracture_____
❑ Amputation_____
❑ Paralysis_____
❑ Other, specify

❑ Hearing deficit
❑ Speech deficit
❑ Endurance
❑ Ambulation
❑ Legally blind

❑ **NO LIMITATIONS**

ACTIVITY LEVEL

❑ Up as tolerated ❑ Exercises prescribed ❑ Transfer bed/chair
❑ Independent in home ❑ Full weight bearing ❑ Partial weight bearing
❑ Bedfast ❑ Sleeps in recliner
❑ Other, specify

❑ **NO LIMITATIONS**

CURRENT MEDICATIONS/TREATMENTS

See Physician's Order Sheet

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

SUMMARY OF CONDITIONS/FUNCTIONAL STATUS

❑ I have reviewed the information provided by the resident/family in Section 1.

❍ I DO ❍ I DO NOT feel this person is appropriate for assisted living/residential care at this time.

SIGNATURES

Resident/Applicant _____ _____ Physician_____ _____

Date *Date*

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed