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**

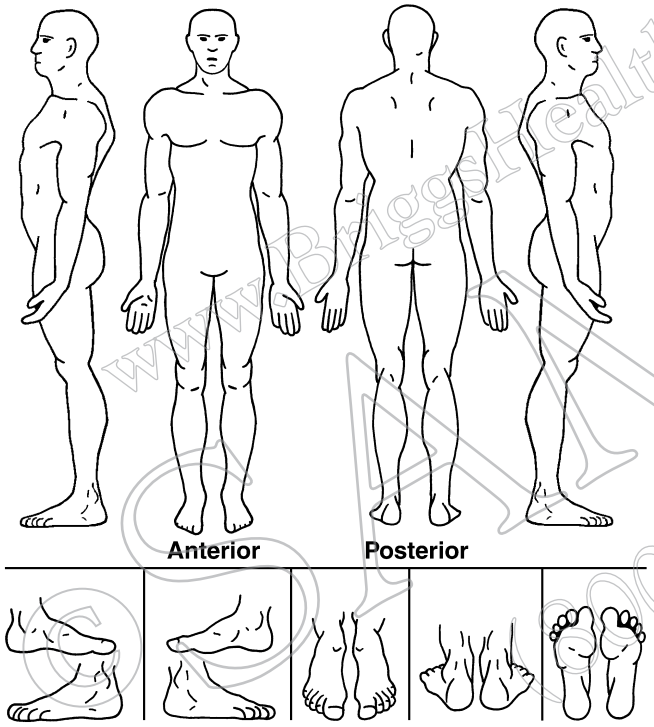
NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

**MEDICAL HISTORY/PHYSICAL/
FUNCTIONAL ASSESSMENT**

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_____
❑ Hearing deficit
❑ Speech deficit
❑ Endurance
❑ Ambulation
❑ Legally blind
❑ Other, specify_____
_____
_____
_____
_____
_____
_____ ❑ **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

MEDICAL HISTORY/PHYSICAL/ FUNCTIONAL ASSESSMENT