House of the Good Shepherd
Physician Admission Medical Assessment

Patient's Name: _____Sex: _____
(Last) (First)

Patient's Home Address: _____
(Street/Apt. #)

_____
(City) (State) (Zip Code) (Phone)

Age: _____ Date of Birth: _____ Date of Exam: _____

Application for: Independent Living ☐ Assisted Living ☐ Skilled Nursing ☐

Diagnosis:
Primary/Date of Onset:_____

Secondary: _____

Additional Diagnoses: _____

_____

_____

_____

PPD Step 1 Result: _____ Date Given: _____ PPD Step 2 Result: _____ Date Given: _____

CXR Result: _____ Date Given:_____

Date of Last: Flu Vaccine _____Pneumonia Vaccine: _____

Medications: (include dose, route & frequency) _____

_____

_____

_____

Treatments: _____

Source of medication information: Physician ☐ Patient ☐ Family ☐ Old chart ☐ Pharmacy☐ Other ☐

Current Mental Status (including Orientation, Psych. Dx, Cognitive/Mental Status):

_____

_____

Vital Signs:
HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Allergies: (drug, food, latex, contrast, other): No Known Allergies ☐

	Allergy	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____

Functional Status:	Independent	W/Assist	Unable	Assistance Devices (Specify)
Ambulation	☐	☐	☐	_____
Dressing Bathing/Showering	☐	☐	☐	_____
Transfers	☐	☐	☐	_____
Feeding	☐	☐	☐	_____
Toileting	☐	☐	☐	_____
W/C Propulsion	☐	☐	☐	_____

Bowel Continent ☐ Incontinent ☐
Bladder Continent ☐ Incontinent ☐

Sight Normal ☐ Impaired ☐ Glasses Yes ☐ No ☐
Hearing Normal ☐ Impaired ☐ Hearing Aid Left ☐ Right ☐
Speech Normal ☐ Impaired ☐ Dentures Yes ☐ No ☐

Hx of Falls: Yes ☐ No ☐ If yes, list most recent falls and any past injuries: _____

_____

Hx of Wandering Behavior: Yes ☐ No ☐

Driving Status - Please Check:
Current License: _____ Daytime Only: _____ In-town Only: _____

Comments on Driving: _____

_____

Recommendation for Rehab:
☐ PT Eval. & Tx. (reason) _____

☐ OT Eval. & Tx. (reason) _____

☐ Speech Eval. & Tx. (reason) _____

Any Restriction on Physical Activity: Yes ☐ No ☐

If yes, explain: _____

Diet: Regular ☐ NCS (No Concentrated Sweets) ☐ Renal ☐ NAS (No Added Salt) ☐

Pre-Admission History and Physical

Past Medical/Surgical/Psychiatric History: _____

_____

_____

_____

_____

_____

Tobacco Use: ☐ Current ☐ Past History Controlled Drugs: ☐ Current ☐ Past History

Alcohol Use: ☐ Current ☐ Past History Illegal Drugs: ☐ Current ☐ Past History

Comments:

_____

_____

_____

_____ _____

M. D. Name (Print) Signature

_____ _____

Address Phone No.

_____

Date

Please attach most recent labs.

Rev. 8/17 db