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