MEDICATIONS

_____ Resident will self administer medication   _____ Needs medication administration

_____ Total umber of edication escribed

Any nown llergies? _____ Yes _____ No

If yes, please list:

____

Names/Dosage	

Comments regarding medication use:

Does resident use any over the counter medications or home remedies?

/

Current Medical Diagnoses: (please list)

Current Mental Health Diagnoses: (please list)

Other Problems: (please explain)

Cardiological: _____

Respiratory: _____

Gastrointestinal: _____

Neurological: _____

Muscular/skeletal: _____

Skin: _____

Substance Abuse: _____

History of Falls: (Check One)

_____ None
_____ Some
_____ Frequent

Sleep Habits and Problems: (please explain)

Bladder Control: (Check one)

_____ Continent
_____ Occasional Incontinence
_____ Frequent Incontinence
_____ Total Incontinence
_____ Catheter

Bowel Control: (Check one)

_____ Continent
_____ Occasional Incontinence
_____ Frequent Incontinence
_____ Total Incontinence
_____ Ostomy

Current Therapies/Treatments:

_____ None
_____ Physical Therapy
_____ Occupational Therapy
_____ Speech Therapy
_____ Respiratory Therapy
_____ Wound Clinic -How often and what clinic? _____
_____ Lymphedema Clinic -How often and what clinic? _____
_____ Dialysis Center -What days/time and what center? _____

Oxygen:

_____ Yes
_____ No
If yes, how many liters?
_____

COVID Vaccinated:

_____ Yes
_____ No
If yes, how many shots/ boosters? _____

Vision: (with glasses if used)

_____ Adequate
_____ Impaired
_____ Severely impaired
_____ Blind

Hearing: (with hearing aid if used)

_____ Adequate
_____ Impaired
_____ Severely impaired
_____ Deaf

Communication:

Primary Language: _____

Able to: (Check all that apply)

_____ Understand
_____ Speak
_____ Read
_____ Write

Diet Information:

Currently on special diet ordered by physician? _____ Yes _____ No
Is patient following the prescribe diet? _____ Yes _____ No

Please specify diet type:

_____ Low fat
_____ Restricted sodium
_____ Diabetic
_____ Lactose intolerance
_____ Liquid
_____ No restrictions
_____ Liquid
_____ Kidney friendly
_____ Carb Control
_____ High Protein
_____Regular diet with added nutrients
_____ Other - please explain: _____

Height: _____
Weight: _____
Appetite: _____

Potential Diet Problems: (please check one)

Yes	No	
_____	_____	Does patient have mouth or tooth problems that make it hard to chew?
_____	_____	Has patient gained or lost ten or more pounds in the last six months without wanting to?
_____	_____	Is patient able to feed them self?
_____	_____	Does patient have difficulty swallowing?
_____	_____	Does patient have nausea/vomiting?
_____	_____	Does patient have heartburn/reflux?