

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/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
☐ 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				
Amputation				
Communication				
Preparing light meals				
Preparing full meals				
Light housekeeping				
Personal laundry				
Handling money				
Using telephone				
Reading				
Writing				
Managing Medications				
Other (Specify)				

APPLIANCES / AIDS / EQUIPMENT

☐ Canes ☐ Walker ☐ Crutches
☐ Wheelchair
☐ Brace ☐ Orthodontic (Specify) _____

☐ Bedside Commode
☐ 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
☐ Presbyopia: R / L ☐ Legally blind
☐ Refractive _____
☐ Cataract surgery: Site _____ Date _____ / _____ / _____
☐ Other (specify, incl. hx) _____
☐ NO PROBLEM

EARS
☐ Holo: R / L ☐ Deaf: R / L ☐ Hearing aid: R / L
☐ Vertigo ☐ Tinnitus ☐ Cerumen
☐ Other (specify, incl. hx) _____
☐ NO PROBLEM

HEAD/NECK

☐ Headache (☐ see Neurological section)
☐ Injuries/Wounds (☐ see Skin Condition/Wound section)
☐ Masses/Nodes: Site _____ Size _____
☐ Alopecia _____
☐ Other (specify, incl. hx) _____
☐ NO PROBLEM

VITALS/ALLERGIES

T: _____ Q O ☐ T ☐ A ☐ H ☐ W ☐
Resp: _____ ☐ Rag ☐ Rag ☐ Rag
Pulse: A _____ R _____ F _____ ☐ Rag ☐ Rag

BP	LYING	SITTING	STANDING
RIGHT			
LEFT			

Allergies: ☐ None Known ☐ Aspirin ☐ Sulfis ☐ Penicillin ☐ Pollen
☐ Eggs ☐ Milk Products ☐ Insect Bites ☐ Other _____

NOSE/THROAT/MOUTH

NOSE
☐ Congestion ☐ Epistaxis
☐ Loss of smell ☐ Sinus prob.
☐ Other (specify, incl. hx) _____
☐ NO PROBLEM

THROAT
☐ Dysphagia ☐ Hoarseness
☐ Lesions ☐ Sore throat
☐ Other (specify, incl. hx) _____
☐ NO PROBLEM

MOUTH
☐ Dentures: Upper / Lower / Partial ☐ Masses/Tumors
☐ Gingivitis ☐ Ulcerations ☐ Toothache
☐ Bridge: ☐ Removable ☐ Permanent
☐ Other (specify, incl. hx) _____
☐ NO PROBLEM

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

Long Term Care Documentation Forms

Xiaolong Qi



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100 Essential Forms for Long-Term Care Carol Marshall, Kate Brewer, Julie Ann Kemman, Heather Stewart, 2014-10-24

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Williams & Wilkins, 2008. Thoroughly updated for its Second Edition, this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records, EMRs, complete guidelines for documenting JCAHO safety goals and new information on charting pain management. Hundreds of filled in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal safeguards and advice for special situations. Appendices include NANDA taxonomy, JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses. **60 Essential Forms for Long-term**

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