

# 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				
Ambulation				
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: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ T: \_\_\_\_\_ A: \_\_\_\_\_ H: \_\_\_\_\_ W: \_\_\_\_\_  
Resp: \_\_\_\_\_ ☐ Reg ☐ Irreg. ☐ Irreg.  
Pulse: A \_\_\_\_\_ R \_\_\_\_\_ F \_\_\_\_\_ ☐ Reg ☐ Irreg.

BP	LYING	SITTING	STANDING
RIGHT			
LEFT			

Allergies: ☐ None Known ☐ Aspirin ☐ Sulfas ☐ 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

**Xiang Xie**



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## **Table of Contents Long Term Care Documentation Forms**

1. Understanding the eBook Long Term Care Documentation Forms
  - The Rise of Digital Reading Long Term Care Documentation Forms
  - Advantages of eBooks Over Traditional Books
2. Identifying Long Term Care Documentation Forms
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Long Term Care Documentation Forms
  - User-Friendly Interface
4. Exploring eBook Recommendations from Long Term Care Documentation Forms
  - Personalized Recommendations
  - Long Term Care Documentation Forms User Reviews and Ratings
  - Long Term Care Documentation Forms and Bestseller Lists
5. Accessing Long Term Care Documentation Forms Free and Paid eBooks
  - Long Term Care Documentation Forms Public Domain eBooks
  - Long Term Care Documentation Forms eBook Subscription Services
  - Long Term Care Documentation Forms Budget-Friendly Options
6. Navigating Long Term Care Documentation Forms eBook Formats

- ePub, PDF, MOBI, and More
- Long Term Care Documentation Forms Compatibility with Devices
- Long Term Care Documentation Forms Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Long Term Care Documentation Forms
  - Highlighting and Note-Taking Long Term Care Documentation Forms
  - Interactive Elements Long Term Care Documentation Forms
- 8. Staying Engaged with Long Term Care Documentation Forms
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Long Term Care Documentation Forms
- 9. Balancing eBooks and Physical Books Long Term Care Documentation Forms
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Long Term Care Documentation Forms
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Long Term Care Documentation Forms
  - Setting Reading Goals Long Term Care Documentation Forms
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Long Term Care Documentation Forms
  - Fact-Checking eBook Content of Long Term Care Documentation Forms
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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