INDEPENDENT LIVING

PRE-RESIDENCY HISTORY & PHYSICAL EXAMINATION

NAME:_________________________________DATE OF BIRTH______________

1. **PAST HISTORY**

   A. PLEASE PLACE A CHECK MARK NEXT TO ANY CONDITION LISTED BELOW THAT IS PERTINENT TO YOUR PATIENT.

_____ULCER	**_____ARTHRITIS**	**_____MENTAL ILLNESS**
_____THYROID	**_____DEMENTIA**	**_____CVA/TIA**
_____CANCER	**_____LUNG DISEASE**	**_____HERNIA**
_____HEART DISEASE	**_____DIABETES**	**_____VISION LOSS**
_____HEARING LOSS	**_____KIDNEY DISEASE**	**_____EPILEPSY**
_____PARALYSIS	**_____HYPERTENSION**	**_____HX OF ALCOHOL OR SUBSTANCE ABUSE**

_____SMOKER, IF SO HOW LONG

PLEASE EXPLAIN POSITIVE FINDINGS BELOW:

____

____

IF PATIENT HAS A DIAGNOSIS OF DEMENTIA PLEASE EXPLAIN WHICH TYPE AND ATTACH A COPY OF MOST RECENT COGNITIVE TEST.

B. HOSPITALIZATIONS

SURGERY (LIST TYPE AND DATE OF SURGERY):

____

FRACTURES (LIST TYPE OF FRACTURE AND DATES):

____

ADDITIONAL COMMENTS REGARDING THE ABOVE INFORMATION:

____

2. PRESENT HEALTH EXAMINATION:

A. HEIGHT_____ WEIGHT_____ BLOOD PRESSURE______RESP.______
PULSE______OXYGEN USE/CONCENTRATOR______________

EYES________EARS_______NOSE______MOUTH_______THROAT______

THYROID_____MURMURS_____RHYTHM______LUNGS_____ABDOMEN____

REFLEXES______EXTREMITIES______.

B. AMBULATION
_____INDEPENDENT_____CANE_____WALKER_____W/C_____ELECTRIC SCOOTER______________

C. MENTAL/BEHAVIOR CONDITION
_____ORIENTED TO PERSON, PLACE AND TIME?
_____FORGETFUL? _____CONFUSED______ADDITIONAL COMMENTS:____________________________________

D. CAPABLE OF INDEPENDENT LIVING?_____YES_____NO
NEEDS ASSISTANCE WITH ADL'S?________________________________
IS YOUR PATIENT ON A SPECIAL DIET?______YES______NO
IF YES THEN PLEASE SPECIFY.____________________________________

3. **CURRENT HEALTH STATUS**

   ANY DRUG ALLERGIES AND/OR SENSITIVITIES? _____YES_____NO

   PLEASE LIST:____

   DOES PATIENT WEAR HEARING AIDS_____YES_____NO

   DENTURES_____YES_____NO

   CONTINENT OF BOWEL_____YES_____NO

   CONTINENT OF URINE_____YES_____NO

   EXPLAIN:____

   IS PATIENT FREE OF COMMUNICABLE DISEASES AND ACTIVE TB?

   _____YES_____NO DATE OF LAST TB TEST/CXR________________

4. **PLEASE LIST MEDICATIONS CURRENTLY TAKING.**

   ____

   ____

   ____

   ____

   ____

   IS PATIENT ABLE TO ADMINISTER OWN MEDICATION OR WILL THEY REQUIRES ASSISTANCE?_____________________________________

5. **LIST CURRENT DIAGNOSIS:___________________________________**

   ____

   IS PATIENT AWARE OF DIAGNOSIS?____________________________

6. **PHYSICIAN INFORMATION:**

   HOW LONG HAS PATIENT BEEN UNDER YOUR CARE?______________

   WILL YOU CONTINUE TO PROVIDE PHYSICIAN SERVICES TO THIS PATIENT AFTER HE/SHE MOVES TO TREYTON OAK TOWERS?________________

   IF PATIENT MOVES INTO THE INDEPENDENT LIVING SECTION PLEASE BE AWARE THAT FOR YOUR CONVENIENCE WE HAVE AN IN HOUSE THERAPY GROUP AND A LAB COMPANY THAT COMES IN DAILY FOR LAB DRAWS AND CAN PROVIDE NURSING ASSESSMENTS IF NEEDED.

AT THE TIME OF THIS APPLICATION, I FIND___________________________
TO BE PHYSICALLY AND MENTALLY CAPABLE OF LIVING IN AN <u>INDEPENDENT</u> LIVING SETTING AND IS FREE OF COMMUNICABLE DISEASE, INCLUDING TB IN AN ACTIVE STATE. STEP 1 AND 2 TB SKIN TEST OR CXR HAS BEEN COMPLETED (IE ADMINISTERED AND READ) PRIOR TO ADMISSION.

TB TEST ADMINISTERED DATE:____________RESULTS:___________________

2ND STEP TB TEST ADMINISTERED DATE:_________RESULTS:_____________

OR

CXR: DATE:__________________________RESULTS:______________________

__________________________ _________________________________

PHYSICIAN NAME PRINTED PHYSICIAN SIGNATURE

____

ADDRESS CITY AND STATE ZIP CODE

_________________________ ______________________________

PHONE NUMBER DATE

PLEASE RETURN TO: TREYTON OAK TOWERS RESIDENCY DEVELOPMENT
211 WEST OAK STREET
LOUISVILLE KY 40203
FAX# 502-589-7263