



6684 Randolph Blvd  
Live Oak, Texas 78233  
210-455-1919 Office  
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Please fill this form out in its entirety.

DNR: YES OR NO  
On File \_\_\_\_\_

**The Basics**

Resident Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Nickname (if applicable): \_\_\_\_\_ Room Number: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_  
Primary Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Contact's Relationship to Resident/Patient: \_\_\_\_\_  
Email Address : \_\_\_\_\_

**Medical History & Current Status**

► **Current Medical Conditions** (Note any diagnosis along with any medical issues or concerns.)

- \_\_\_ Dementia \_\_\_ Heart Disease \_\_\_ Thyroid Disease \_\_\_ Diabetes \_\_\_ COPD
- \_\_\_ Hypertension \_\_\_ Prostate \_\_\_ Heart Failure \_\_\_ Kidney Disease
- \_\_\_ Liver Disease \_\_\_ Seizures \_\_\_ Psychiatric \_\_\_ Cancers (type) \_\_\_\_\_

**Behaviors:**

- \_\_\_ Verbal Aggression \_\_\_ Hitting \_\_\_ Spitting \_\_\_ Biting \_\_\_ Yelling \_\_\_ Sexual
- \_\_\_ Wandering \_\_\_ Exit Seeking \_\_\_ OTHER: \_\_\_\_\_

► **Immunity & Immunizations** (Please write the month and year on the line provided.)

Flu Shot \_\_\_\_ / \_\_\_\_  Pneumonia \_\_\_\_ / \_\_\_\_  Tetanus \_\_\_\_ / \_\_\_\_  
 Covid 19 \_\_\_\_ / \_\_\_\_ PPD Status \_\_\_\_\_ as of \_\_\_\_ / \_\_\_\_

Any known allergies? \_\_\_\_\_

► **Previous Medical Conditions** (Note any medical conditions in your past. If applicable note if the condition was resolved by surgery, medication or other means.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

► **Previous Hospitalizations** (Please write the month and year on the line provided.)

Reason: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Notes: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_

Notes: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_

Notes: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_

Notes: \_\_\_\_\_

► **Previous Surgeries** (Please write the month and year on the line provided.)

Type: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_

Notes: \_\_\_\_\_

## Functioning

### ❖ APPEARANCE

(For the following questions, if an assistive device or prosthetic is working and causes any diminished capacity to be normal, mark it as “good.”)

<b>Communication</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Needs Attention _____
<b>Dental Health</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Needs Attention _____
<b>Feet</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Needs Attention _____
<b>Hearing</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Needs Attention _____
<b>Vision</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Needs Attention _____
<b>Skin Condition</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Needs Attention _____

### ❖ ACTIVITIES OF DAILY LIVING (ADL)

<b>Bathing</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Some Assistance	<input type="checkbox"/> Dependent
<b>Dressing</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Some Assistance	<input type="checkbox"/> Dependent
<b>Grooming</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Some Assistance	<input type="checkbox"/> Dependent
<b>Eating</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Some Assistance	<input type="checkbox"/> Dependent
<b>Transfers</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Some Assistance	<input type="checkbox"/> Dependent
<b>Ambulation</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Assistive device (cane/wheelchair)	<input type="checkbox"/> Cannot Ambulate

### ❖ CONTINENCE

<b>Urine</b>	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Occasionally Incontinent
<b>Stool</b>	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Occasionally Incontinent
<b>Catheter</b>	<input type="checkbox"/> Yes		

❖ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

**Personal**

Former Occupation: \_\_\_\_\_ Military Affiliation: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Notes on Customary Daily Routine: Things to Know (likes/dislikes, pet peeves): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dietary**

\_\_\_ Has natural teeth \_\_\_ Dentures (circle all that apply) Full Partial Upper Lower  
Pain in mouth: YES NO

DIET: REGULAR MECHANICAL PUREE RENAL CARDIAC RELIGIOUS \_\_\_\_\_  
OTHER: \_\_\_\_\_

Favorite Foods: \_\_\_\_\_  
Does not like: \_\_\_\_\_  
Sensitivities or allergies: (include any reactions) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Wishes & Protocols**

- Durable Power of Attorney  
Name & Contact Details: \_\_\_\_\_
- Medical Power of Attorney or Healthcare Proxy  
Name & Contact Details: \_\_\_\_\_
- Advanced directives  
Contact person and phone numbers \_\_\_\_\_

RESIDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
RESPONSIBLE PARTY \_\_\_\_\_ DATE \_\_\_\_\_

Company Representative: \_\_\_\_\_