The Judy & Josh Weston Assisted Living Residence
Resident Medical History and Physical Examination Record

Instructions: This person has applied for residency at our assisted living residence and the NJ Department of Health and Senior Services requires a record of medical history and a physical examination with-in 30 days prior to moving into our Community. Please complete this form. If you have any questions, please call 973-929-2745 to speak with the facility Director of Wellness Program.

Name SS#
Date of Birth: Medicare #
Drug or Food Allergies:
Medical Conditions/ Diagnosis:
Medical / Surgical History:
MUST BE FILLED OUT PRIOR TO ADMISSION.
Immunizations: Pneumonia Vaccine: Yes □ Date Given: Not Given □
Influenza Vaccine: Yes □ Date Given: Not Given □
Tetanus Vaccine: Yes □ Date Given: Not Given □
Tuberculin Testing / Two-Step Mantoux: Yes □ No □
First Step Date Given: Results: mm
Second Step Date Given: Results: mm
If reactive, was chest x-ray done: Yes □ Date: No □
X-Ray Results:
In your opinion, can this person safely self-administer his / her own medication?
Yes □ No □ If No, please explain:
In your opinion, is this person appropriate for placement in assisted living?
Yes □ No □ If No, please explain:
Does this person require devices or equipment to assist them with safe ambulation
or to perform activities of daily living? Yes □ No □ If Yes, please specify:

Physician Signature: _____ Date: _____
Resident Name: _____

PHYSICAL ASSESSMENT:
Temp: BP: Pulse: Respirations:
Height: Weight:
REVIEW OF SYSTEMS
HEENT:
Neck:
Chest:
Cardio-Vascular:
GI:
GU / Renal:
Skeletal (joints):
Integumentary:
Neurological:
Mental / Cognitive:
Emotional:
Please share any other information about your patient that would be helpful in planning
and providing his / her care.
Does this person have Do Not Resuscitate, Advance Directives or treatment restrictions?
Yes □ No □ If No, please explain:
If Yes, please specify:

Physician Signature: _____ Date: _____
Resident Name: _____

Physician Name Printed: _____
Address: _____
Phone Number: _____Fax Number: _____

CURRENT MEDICATION

Please attach prescriptions for all medications currently prescribed if person will be participating in a Medication Management Plan. Include all prescription and non-prescription medications, eye drops, topical creams or ointments, vitamins, supplements and herbal preparations.
As required by law, include all the following information on the prescription:

-Patient's name and address
-Name of medication
-Strength of medication
-Dose
-Dosage Form
-Time or frequency of administration
-Route of administration
-Quantity to dispense or duration of therapy
-Name and signature of prescribing licensed practitioner
-Refill authorization
-Date

For PRN medications and frequently used over-the-counter preparations, please specify:

- The frequency of administration
- Maximum daily dose
- Condition for which the medication is being administered (e.g. pain, sleep, indigestion, dry eyes, constipation)
- Duration of therapy

If this person is able and will be self-administering medications, please provide a list of all current medications and associated diagnosis for our records.

Medication & Dosage	Frequency & route	Diagnosis

Physician Signature: _____Date: _____
Resident Name: _____