HALE HO ALOHA
Come Home to Aloha
2670 Pacific Heights Road
Honolulu, HI 96813
Phone: (808) 524-1955 Fax: (808) 537-5418

History & Physical / Admitting Orders

Resident: _____ _____ _____
Last Name First Name Middle

Primary Physician _____

Address _____

_____

MD Phone # _____

List all current medical diagnoses:

_____ _____

_____ _____

_____ _____

_____ _____

List all medications below, including PRNs and over-the counter meds and vitamins:

Medication	**Dose**	**Route**	**Frequency**

Resident's Name _____

Present Illness:

_____
_____
_____

Past History:

_____
_____
_____

Injuries/Operations:

_____
_____
_____

INVENTORY BY SYSTEMS – General

Skin _____

Head – EENT _____

Respiratory _____

Cardiovascular _____

Genitourinary _____

Gynecological _____

Musculoskeletal _____

Abdomen _____

Extremities _____

Neurological _____

Pyscho-Social _____

If Diabetic,
Blood sugar checks: □ No □ Monthly □ Weekly □ Daily □ Other: _____
Blood sugar parameters: Blood sugars should be < _____ and > _____

Resident's Name: _____

Treatments, including dose and frequency (for topical medications include area(s) of application):

_____
_____
_____

Allergies: _____

Diet_____ **Liquid Consistency** _____

Mobility Status: _____Ambulatory ___Ambulatory w/ assist _____Non-ambulatory

P.T. Eval _____YES ___NO **Laxative PRN** _____
O.T. Eval _____ YES ___ NO **Enema PRN** _____|

Pneumovax Given _____ Flu Vaccine Given _____
Date Date

Patient is free from communicable disease: YES _____ NO (specify) _____

TB (2 step Mantoux or chest x-ray required:

PPD First step date given: _____ date read: _____ results: _____
Read by: _____

PPD Second step date given: _____ date read: _____ results: _____
Read by: _____

PYSICIAN'S SIGNATURE _____

DATE _____