Resident Medical Information Form

Patient Information

First Name:

Last Name:

Date of Birth:

Weight:

Street Address:

City:

Zip Code:

Date Completed:

Family Contact Information

Name:

Relationship:

Phone Number:

Hospital Preference

Primary:

Alternate:

Primary Care Physician

Name:

Number:

DNR / POLST

DNR (Do Not Resuscitate) Yes ☐ No ☐

POLST (Physicians Orders for Life-Sustaining Treatments) Yes ☐ No ☐

Include applicable DNR or POLST orders behind the Resident Medical Information Form

Allergies to Medications

(Check all that apply & list additional below)

Amoxicillin	☐	Iodine	☐
Aspirin	☐	Morphine	☐
Cipro	☐	Penicillin	☐
Codeine	☐	Sulfa Drugs	☐

Other:

Medical History

(Check all that apply & list additional below)

☐ Asthma
☐ Cancer
☐ Cardiac Dysrhythmia / Arrhythmia
☐ Cardiac Pacemaker
☐ Cardiac Angioplasty / Stent
☐ Cardiac CABG
☐ Cardiac Heart Failure
☐ Cardiac Myocardial Infarct
☐ Cardiac Other
☐ Dementia / OBS
☐ Diabetes
☐ GI / GUI – Ulcer / Reflux
☐ Hypertension
☐ Neurological – Paraplegia
☐ Psychiatric / Behavioral / Anxiety
☐ Renal Disease / Dialysis
☐ Respiratory – COPD / Emphysema / Bronchitis
☐ Seizure
☐ Stroke / TIA
☐ Substance Abuse

Other: 1)
2)
3)
4)
5)

Medications

(List all medications below)

1)
2)
3)
4)
5)
6)
7)
8)
9)
10)
11)
12)