Saint Anne COMMUNITIES
Faith centered. Family focused.

HISTORY & PHYSICAL FORM

☐ New Admission
☐ Transfer
☐ Annual

Patient Name	Sex	Date of Birth
Address	City/State	Phone
Relative/Guardian Name & Address	City/State	Phone

Active Diagnoses & Conditions	**Current Medications & Treatments / Supporting Diagnoses**	**Surgeries/Procedures & Medical History**	**Allergies** (include reaction)
	May crush meds _Yes _No	May consume alcohol: _Yes _No	

Family & Social Hx

Family History: _Diabetes _Heart Disease Other:_____ _Cancer _____	**Tobacco Use:**_____ Amt:_____ Date Quit:_____	**Alcohol Use:** _____ Amt: _____	**Illicit Drug Use:** _____ _____

Vitals

B/P	Pulse	Respirations	O2 Sats
Temp	Height	Weight	BMI

Physical Exam

	N	AB		N	AB
1. General Appearance			12. Abdomen		
2. Skin			13. Extremities		
3. Nodes			14. Pulses		
4. Head & Neck			15. Neurological		
5. Eyes			16. Gait		
6. Throat			17. Grasp		
7. Ears			18. Genitalia		
8. Nose			19. Recent Pap		
9. Chest			Oral Exam: Gums		
10. Lungs			Teeth		
11. Heart			Tongue		

Describe abnormal findings indicated on Physical Exam

Pt has been informed of condition(s):
☐ **Yes** ☐ **No** (specify why) _____
_____

Cognition	**Elimination**	**Skin Condition**
_Alert _Oriented x_____ _Confused _Memory Loss _____	Bowel: Bladder: _Continent _Continent _Incontinent _Incontinent _Last BM _Foley Size: _____ _Colostomy _Last Changed	Wounds/Decubitus (Size, Location) _____ _____ _____

Nutrition	**Mobility**	**Misc**
Diet:_____ _____ _Feeds Self _Requires Assist	_Self _Prosthesis:_____ _Walker _Bed Rest _Assist 1-2 _Amb as Tol. _Side Rails _Restraints _Other:_____	_Dentures _Hearing Aids _Glasses/Contact Lenses _Other assistive devices: _____

Therapies:	**Rehab Potential:**	**Certified for:**
PT:_____ OT:_____ Speech:_____ RT:_____	_Good _Fair _Poor	_Skilled _Intermediate _Residential/Assisted Living

Pt is free from communicable diseases including active TB?
☐ Yes ☐ No
_____

Physician's Signature:	Physician Name:	Date: