Healthcare Practitioner Form

Name:	Gender:
Date of birth:	Date:
Emergency contact name:	
Emergency contact number:	
Emergency contact relationship:	
Current medical and psychiatric history	
Indicate recent changes in health or behavioral status, hospitalizations, suicide attempts, falls, etc, within 6 months.	
Medical history	
Describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.	
Allergies	
List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem.	
Communicable diseases	
Is the patient free from communicable TB and other active reportable airborne communicable disease(s)?	
☐ Yes	☐ No
Indicate the disease:	
List the tests done to verify the patient is free from active communicable disease	

Drug abuse history		
Does the patient have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?		
Substance: OTC, non-prescription medication abuse or misuse	Recent (within 6 months):	☐ Yes ☐ No
	History:	☐ Yes ☐ No
Abuse or misuse of prescription medication or herbal supplements	Currently:	☐ Yes ☐ No
	Recent (within 6 months):	☐ Yes ☐ No
History of non-compliance with prescribed medication	Currently:	☐ Yes ☐ No
	Recent (within 6 months):	☐ Yes ☐ No
Describe misuse or abuse:		

Risk factors for falls and injuries	
Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply)	
☐ Osteoporosis	☐ Confusion
☐ Parkinsons	☐ Foot deformity
☐ Pain	☐ Orthostatic hypotension
☐ Gait problem	☐ Impaired balance
☐ Assistive devices	☐ Other (explain):

Skin conditions
Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders.

Sensory impairments affecting function (check all that apply):	
Left ear	☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid
Right ear	☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid
Vision	☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind ☐ Left ☐ Right

Temperature sensitivity	☐ Normal
	Decreased sensation to: ☐ Heat ☐ Cold
Current nutritional status	
Height (inches):	Weight (lbs):
Weight change (gain or loss) in the past 6 months	☐ Yes ☐ No
How much weight change?	____ lbs in the past _____ months
Is there evidence of malnutrition or risk for undernutrition?	☐ Yes ☐ No
Is there evidence of dehydration or a risk for dehydration?	☐ Yes ☐ No
Any medical or dental conditions affecting: (Check all that apply)	☐ Chewing ☐ Swallowing ☐ Eating ☐ Pocketing food ☐ Tube feeding
Medications	
Include dosage route, frequency, duration	What diagnoses are currently being treated by this medication?
Prescriber signature:	Date:
Phone:	Address:
Signatures	
Patient:	Date:
Healthcare provider:	Date:

Adapted from

Maryland Department of Health. (n.d). *Health care practitioner physical assessment form*.https://health.maryland.gov/ohcq/docs/AL%20Forms/hcppa.pdf?csf=1&e=nksaYx