



# 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)