BETHANY HOME

1005 Lincoln Avenue Dubuque IA 52001 563.556.5233 bethanyhomedubuque.org

PREADMISSION MEDICAL HISTORY *(To be completed by Physician Only.)*

Name of Applicant _____ ❒ Female ❒ Male

Name of Physician _____ Date Completed _____

DOB _____ Weight _____ Height _____ Temp _____ Pulse _____ Resp. _____ B/P _____

History of drug addiction?: ❒ Y ❒ N _____
History of alcohol addiction?: ❒ Y ❒ N _____

Evidence or History of the Following:

Chronic Lung Disease: ❒ Y ❒ N _____
Cardiovascular Disease: ❒ Y ❒ N _____
Gastrointestinal disease: ❒ Y ❒ N _____
Genitourinary Dysfunction or Disease: ❒ Y ❒ N _____
Anemia: ❒ Y ❒ N _____
Neurological Disease: ❒ Y ❒ N _____
Arthritis: ❒ Y ❒ N _____
Psychiatric Diagnosis: ❒ Y ❒ N _____
Skin Condition: ❒ Y ❒ N _____
Impairment of Sight?: ❒ Y ❒ N _____
Impairment of Hearing: ❒ Y ❒ N _____
Diabetes: ❒ Y ❒ N _____
Malnutrition: ❒ Y ❒ N _____
Allergies: ❒ Y ❒ N _____
Mental Status: ❒ Y ❒ N _____
Other: _____

Urinalysis: _____

Date and Results of Last Chest X-ray/T.B. Mantoux _____
(Results of Chest X-Ray or Mantoux must be within the last 90 days.)

Last Flu Vaccination Date: _____ Last Pneumovax Date: _____

Restoration Potential: ❒ Good ❒ Fair ❒ Poor ❒ Terminal

Physician's Recommendation of Care: ❒ Apartment ❒ Healthcare (nursing facility) ❒ Memory Unit

ALL RESIDENTS OF NURSING FACILITIES WHO ARE MEDICAID (TITLE XIX) RECIPIENTS ARE REQUIRED TO BE SEEN BY THEIR PHYSICIANS EVERY THIRTY (30) DAYS FOR THE FIRST NINETY (90) NINETY DAYS; THEN EVERY SIXTY (60) DAYS THEREAFTER.

In order to comply with state regulations our resident's records must contain a medical diagnosis for each medication that is given. In the area below, please list this applicant's current medications and their corresponding diagnosis.

Current List of Medications	Corresponding Diagnosis

Other Diagnosis:

Diet Restrictions: ❒ Y ❒ N _____

Activity Level as Tolerated: ❒ Y ❒ N _____

List Any Limitations:

Is the Applicant Presently Capable of Minimal Alcohol Consumption?: ❒ Y ❒ N

Physician's Signature _____ Date _____

I, the undersigned, give my physician permission to release all pertinent information necessary to complete this form for my admission to Bethany Home, Dubuque, IA.

Applicant's Signature _____ Date _____