The Fountainview Center for Alzheimer's Disease
2631 North Druid Hills Rd. N.E.
Atlanta, Georgia 30329
(404) 325-7994
(404) 325-1213 – Fax
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MEDICAL HISTORY AND ADMISSION EXAMINATION

Resident Name: _____ Room #: _____
Attending Physician: _____
Physician's Phone: _____
Office Home Answering Service

Objective of Care:
Rehabilitation _____
Maintenance _____
Terminal _____

If applicable--Rehabilitation Potential:
Excellent _____
Fair _____
Poor _____

MEDICAL HISTORY

(Complete Where Applicable)

Diabetes _____ Epilepsy _____ Arthritis _____
Kidney: Last Diagnosis_____
CVA: Last Diagnosis _____
Tuberculosis: Last Diagnosis _____
Date of Last Chest X-Ray _____ Place _____
Other Lung Condition: _____
Last Diagnosis _____
_____
Heart: Last Diagnosis _____
_____
Cancer: Last Diagnosis_____
_____
Mental Illness: Yes _____ No _____ Periods of Hospitalization _____
_____
Other Diseases (Specify) _____
_____
Permanent Disabilities _____
_____
Operations _____
_____
Habits: Coffee _____ Tea _____ Smoking _____ Alcohol _____
Narcotics _____
Dietary History
_____
Sensitivities to Drug and Allergies _____

Continence: Continent _____ Incontinent: Feces Only _____
Urine Incontinent _____ Incontinent: Feces & Urine _____
Chief Complaints: Current _____
_____

ADMISSION EXAMINATION

Age _____ Height _____ Weight _____ Blood Pressure _____
Temperature _____ Pulse _____ Respiration _____
Physical Condition: Good _____ Fair _____ Poor _____
Mental Condition: Clear _____ Partly Confused _____ Badly Confused ____
Ambulation: Self _____ With Assistance _____ Not Ambulatory ____
Head: Eyes _____
Ears _____
Teeth _____ Dentures _____
Chest: Heart _____
Lungs _____
Abdomen _____
Pelvis _____
Back _____
Extremities _____
Open Lesions or draining sinuses _____
Recent Culture Result and Date, if applicable _____
Behavior Problems _____
_____
Does patient have a communicable disease? If so, explain _____
_____
Explain any other special problems, such as emotional disorders, speech, paralysis, arteriosclerosis, or Arthritic condition _____
_____
_____
Functional Limitations or special needs _____
_____
_____
Admission Diagnosis, state fully (if surgical, state procedure and date) _____
_____

Signature Attending Physician _____ Date _____