History & Physical

Patient Name-___________________________
Primary Insurance- ______________________
Secondary Insurance-____________________
Home Health Company- __________________
Allergies-_______________________________
Pharmacy-______________________________
Pharmacy Phone- _______________________
Height____________ Weight_______________

- Low Vision
- Shortness of Breath
- Uses Oxygen
- Diabetes if yes- Last Hemoglobin A1C ______
- Kidney Failure
- Poor Circulation
- Swelling
- Pain in Legs
- Bladder Accidents
- Bowel Accidents
- Long term steroid use
- Immunosuppressive drugs
- Anemia if yes, last Hemoglobin _____
- Anxiety/Depression
- Chair Sleeping
- Malnutrition
- Paralysis
- Chairbound or Bedbound
- Catheter
- Ostomy
- Smoker- circle one- Never Former Current
- Weight loss in the last 3 months- Circle one- None between 1-6 pounds More than 6 pounds
- Any Falls in the last year
- Assistive device- Circle one- None Cane Walker Wheelchair Other