Resident Name and ID #:_____

Resident History Form

Resident Name:_____ Resident #:_____ DOB:_____

Admit Date:_____ **DNR/DNI** or **FULL CODE** Status (circle one)

Allergies:_____

Medical History			
Primary Care/Specialists			
Provider's Full Name	**Specialty**	**Phone**	**Reason**

Surgical History	
Date	**Type of Surgery/Procedure**

Preventive Care	
Recent Immunizations	**Date**
Flu	
Shingles	
Pneumonia	
Tetanus	
COVID-19 (1st Dose, 2nd Dose, Bivalent)	
Recent Test or Procedures	
Colonoscopy	
Mammogram	
Other:	

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Resident Name and ID #:_____

Falls prior to admission:

- ☐ Last 30 days
- ☐ Last 90 days
- ☐ Last 180 days

Current Medications			
Please List All Medications Taken Prior to Admission			
Medication Name	**Dose**	**Times Per Day**	**Reason/Indication/Diagnosis**

Completed by (please print):_____ Relationship to Resident:_____

Signature:_____ Date:_____

Reviewed by:_____ Date:_____

For staff use: Medication Reconciliation Completed? Y/N

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