Maui Adult Day Care Centers

11 Mahaolu Street, Suite B
Kahului, HI 96732
Tel: (808) 871-5804 / Fax: (808) 877-4082

☐ Kahului Facility ☐ Ocean View Facility ☐ West Maui Facility ☐ South Maui Facility

ANNUAL HISTORY AND PHYSICIAN'S FORM

I. PERSONAL INFORMATION (Part I to be completed by the caregiver)

Name: _____

Address: _____

Birthdate: _____ Age: _____ Gender: _____

Caregiver's Name: _____

Relationship: _____ Telephone/Cell #: _____

Physician Name: _____ Telephone #: _____

Alt. Physician: _____ Telephone #: _____

SECTIONS II - XIV MUST BE COMPLETELY FILLED OUT BY THE PHYSICIAN

II. PERTINENT MEDICAL HISTORY: (Attach Summaries)

Major Medical Problems
□ No □ Yes: _____Date: _____

Allergies
□ No □ Yes: _____Date: _____

Surgeries
□ No □ Yes: _____Date: _____

Psychiatric History
□ Yes □ No Diagnosis and Psychiatrist: _____ Date:_____

III. PHYSICAL EXAMINATION:

General: Height_____ Weight_____ Blood Pressure_____ Pulse Rate_____

□ Comatose or Stuporous
□ Depressed
□ Disoriented
□ Belligerent/Combative
□ Noisy
□ Non communicative

HEENT:
Head: _____
Eyes/Vision: _____
Ears/Hearing: _____
Nose: _____
Mouth/Teeth/Throat: _____
Neck: _____

Lungs: _____
Heart: _____
Back-Skeletal: _____
Abdomen: _____
Genitalia/Pelvic: _____
Rectal: _____
Extremities: _____

Ambulation: □ Independent □ Device □ Assistance □ Total incapacity

IV. PHYSICAL AIDS:

□ Dentures □ Eyeglasses □ Hearing Aid □ Colostomy
□ Prosthesis Specify: _____

V. ACTIVITIES FOR DAILY LIVING CAPABILITIES: (Please check)

	Continent	Incontinent
Urine	□	□
Bowel	□	□
Recommended Training	□ Bladder	□ Bowel

	Independent	With Assistance	Total Dependence
Feeding	□	□	□
Dressing	□	□	□
Personal Hygiene	□	□	□
Toilet	□	□	□
Bathing	□	□	□

VI. CURRENT PHYSICIAN ORDERS:

DIET: □ Regular □ Special Specify: _____ □ NG Tube □ Gastrotomy

Present Medications: (Name of drug, dosage, time)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

VII. DIAGNOSIS:

Primary: _____

Secondary: _____

VIII. CURRENT PROBLEMS AND SERVICES REQUIRED: Ancillary Service

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

IX. REHABILITATIVE POTENTIAL:

□ Good □ Fair □ Poor

Anticipated Transfer to: □ SNF □ ICF □ CH □ Day Care Services □ Home
□ Continued Care at this Level

X. TOLERANCE FOR PHYSICAL/RECREATIONAL ACTIVITIES: □ Yes □ No

XI. _____ is able to interact with pre-school aged children: □ Yes □ No
Print Patient's Name

XII. _____ is free of communicable disease: □ Yes □ No
Print Patient's Name

XIII. PHYSICIAN CERTIFICATION:

I _____certify that the patient's medical condition and related
Print Physician's Name
needs are essentially as indicated above and care in this facility is medically necessary:

Physician's Signature _____ Date _____