

Drug/Food Allergies:

- _____
- _____
- _____

Physical Impairments:

Vision: _____

Hearing: _____

Mobility: _____

Current Smoker: Yes or No

Provide a statement describing patient's cognitive functioning. Ability to function in a Level IV Rest Home.

Nutritional Status:

Current Status: _____

Current Diet: _____

IBW: _____

Activity Level:

Current Status: _____

Restriction: _____

