HALE NOHEA
Maunalani

RESIDENT PHYSICAL EXAMINATION RECORD

Name:_____ **Birth Date**:_____

Address_____
Number Street Name City Island Zip Code

Height:_____ **Weight**:_____ **Ears**:_____

Eyes:_____ **Pupils**:_____ **Ears**:_____

VISION: Right:_____ **CORRECT VISION: Right:**_____ **HEARING: Right:**_____

Left:_____ **Left:**_____ **Left:**_____

Nose:_____ **Mouth:**_____ **Teeth:**_____ **Thyroid:**_____

HEART: Rate:_____ **Rhythm:**_____ **Murmurs:**_____

Lungs:_____ **Nervous System:**_____

Abdomen:_____ **Kidneys:**_____

Genitalia/Pelvis:_____ **Hemorrhoids:**_____

Varicosities:_____ **Hernia:**_____

Skin:_____ **Romberg:**_____ **Reflexes:**_____

Extremities: Upper:_____ **Lower:**_____

Other abnormalities:_____

_____

Current medications, if any:_____

_____

_____

Resident is ambulatory and capable of following directions and taking appropriate action for self preservation under emergency conditions: ___Yes ___No

Diagnosis:_____

_____

_____

Diet:_____

_____

Level of Care Assessment:

The Resident is certified as: ___**Independent** ___**ARCH** ___**ICF** ___**SNF**

_____ _____ _____
Print or type physician's name Physician's Signature Date