Admission Profile

NAME: Date of Birth:

HEALTH HISTORY

Primary physician's name: Phone:

Address:

Medicare #: Part A ☐ Part B ☐ SS #:

Health Insurance: Policy #:

Address: Zip:

Other Physician specialist:

Who will be responsible for arranging doctor appointments? ☐ Facility ☐ Family

Who will transport resident to appointments? ☐ Facility Van ☐ Family

Pharmacy you currently use: Phone:

Will you use the facility pharmacy upon admission?: *If no, resident/family is responsible for ordering.

☐ Mail order ☐ VA ☐ Other:

Hospital preference : If an emergency, we will transport to the local hospital.

Homecare agency preference, if other than UPMC HomeCare:

Please indicate the following as excellent, good, fair or poor

Hearing: Eyesight: Ambulation:

Do you use a ☐ Walker ☐ Wheelchair ☐ Cane ☐ Motorized Scooter/Wheelchair

List your last three hospitalizations

Hospital: Year: Reason:

Hospital: Year: Reason:

Hospital: Year: Reason:

Check any of the following conditions that you have or have had in the past:

☐ Heart Disease	☐ High blood pressure	☐ Incontinence	☐ Cancer
☐ Diabetes	☐ Low blood pressure	☐ Memory loss	☐ Tuberculosis
☐ Stroke	☐ Arthritis	☐ Confusion	☐ Cataracts
☐ Paralysis	☐ Limb impairments	☐ Parkinson's disease	☐ Other
☐ Oxygen	☐ Glucose monitoring	☐ Ted hose	

☐ Dentures _____ Upper _____ Lower _____ Partial ☐ Hearing aides _____ left ear _____right ear

List other medical conditions:

Admission Profile

Check any of the following you need assistance with:

- ☐ Ambulation
- ☐ Bathing
- ☐ Toilet
- ☐ Grooming
- ☐ Dressing
- ☐ Eating
- ☐ Medications
- ☐ Telephone use
- ☐ Finances
- ☐ Transportation
- ☐ Housekeeping
- ☐ Laundry
- ☐ Special diet
- ☐ Other
- ☐ Other
- ☐ Other

List medications you are currently taking (if needed use additional paper):

List any allergies you have:

Flu vaccine: ☐ yes Date: ☐ no

Pneumonia vaccine: ☐ yes Date: ☐ no

TB Test: ☐ yes Date: ☐ no

PERSONAL HISTORY

Where have you lived most of your life?:

With whom do you now live? ☐ Wife/husband ☐ Son/daughter ☐ Alone ☐ Other:

Type of current residence:

Length of time at current residence:

Have you applied to any other facility? ☐ yes ☐ no Have you ever lived in another facility? ☐ yes ☐ no

Your profession, trade, or occupation?:

Highest grade level attained in school?:

List volunteer and/or community services in which you have participated:

List hobbies/interests:

List military background:

Registered Voter? ☐ yes ☐ no ☐ Poll ☐ Absentee Ballot

Do you use tobacco? ☐ yes ☐ no Alcohol? ☐ yes ☐ no Narcotics? ☐ yes ☐ no

Who will be doing your personal laundry? ☐ Resident ☐ Family ☐ Facility

Do you have Power of Attorney appointed? ☐ yes ☐ no

If yes: Name: Phone:

Address: Relationship:

Email:

CHURCH LIFE

Denominational affiliation: Congregation:

I have been a church member for years. Pastor's name:

Phone: Address:

I have been involved in the following church-related activities:

FURNITURE

☐ Bringing own ☐ Facility bed ☐ Facility dresser ☐ Facility nightstand ☐ Facility chair

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LIFE CHANGING MEDICINE

SRLIV528332 SR/NC 12/22