Name_____ Health Record Form

HEALTH RECORD

Completed by: _____
Relationship to Individual: _____
Date: _____

To be completed or updated at the ISP and brought to all new medical contacts/ER/Hospitalizations.

Name _____ **Likes to be called** _____
D.O.B. _____ **Religion** _____
Address _____ **Health Insurance (type and numbers)**
_____ Primary: _____
Tel. # _____ Secondary: _____

Agency Responsible for Providing Care? ___ NO ___ Yes _____ Tel _____
(Name of agency/contact person)

Consent Status: ___Can give own consent ___Unable to give consent and no guardian
___Consent from guardian Name _____ Tel # _____

Resuscitation Status: ___DNR If DNR, is comfort care form available? __Yes __No __Unknown
___Full Resuscitation
Guardian/Healthcare Rep : ___No ___Yes Name_____ Tel # _____

Emergency Contacts
#1 Name _____
Telephone _____
#2 Name _____
Telephone _____
Medications: ___ Medication sheet/record attached
OR ___ List attached
Pharmacy: Name: _____ Tel _____
Address: _____

Allergies Medications: _____
Food/Environmental: _____
Type of Reaction: _____

Current Medical Problems and Diagnoses: _____
_____
_____
_____

Communication:
___Able to Communicate
___Communication Difficulties/Uses Verbalizations
___Communication difficulties/Uses Gestures
___Not Able to Communicate Needs
___Unable to Use Call Bell

Vision:
___Normal
___Low Vision
___Blind
___Wears Glasses

Hearing:
___Normal
___Hard of Hearing
___Deaf
___Hearing Aid

Supportive Devices:
___Padded side rails
___Splints
___Braces
___Helmet
___Other

Toileting Ability:
___Continent
___Needs Assistance
___Incontinent
___Catheterized
___Other _____

Medication Administration:
___Independent/Self Medicates
___Medication Administered by Staff

Dining/Eating:
___Independent
___Needs Assistance
___Totally Dependent
___Fed Through a Tube
___Other _____

Diet Texture:
___Regular
___Chopped
___Ground
___Puree
___Thicken Liquid
Diet Type: _____

Ambulation:
___Independent ___Steady ___Unsteady
___Needs Assistance __1 person __2 people
___Ambulation Aids __Walker __Cane __Crutches
___Wheelchair
___Non-Ambulatory

Personal Hygiene:
___Independent
___Special Needs _____

Oral Hygiene:
___Independent
___Special Needs _____

Head of Bed Elevated:
___Yes
___No

Fluid Texture: _____thin (all thicknesses ok)
_____nectar _____honey _____pudding

SPECIAL NEEDS

Usual Response to Medical Exams: __Cooperates __Partially Cooperates ___Resistant ___Fearful
___Sedation for clinical visits (explain): _____
___Special positioning required for examination (explain): _____
___Risk for aspiration/choking (explain):_____
___Double staffing required for assistance with exams (explain): _____
___Requires limited waiting periods for exams
___Prefers early day appointments ___Prefers end of day appointments
___Special communication device/method (explain): _____
Pain Response: ___Normal ___Unique (explain): _____

Adapted for Massachusetts Dept of MR

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MEDICAL PROVIDERS **NAME: _____**

Primary Care	**Subspecialist/Type**
Name _____ Tel # _____ Address_____ _____	Name _____ Tel # _____ Address_____ _____
Dental Care	**Subspecialist/Type**
Name _____ Tel # _____ Address_____ _____	Name _____ Tel # _____ Address_____ _____
Eye Care	**Subspecialist/Type**
Name _____ Tel # _____ Address_____ _____	Name _____ Tel # _____ Address_____ _____

Living Status: ___Group Home ___Own Family ___Independent ___Supportive Living ___Other _____

Marital Status: ___Single ___Married ___Other _____

Work/Day Program Status: ___Community Day Support ___Day Habilitation ___Regular Job ___Sheltered Workshop

Nursing Supports Available: ___In home ___Nursing Coordination ___In home 24 hour ___Access to VNA etc
___No nursing supports

IMMUNIZATIONS

Date of last tetanus	_____	___Unknown	___Allergic	___Never
Date of last Flu shot	_____	___Unknown	___Allergic	___Never
Date of last Pneumovax	_____	___Unknown	___Allergic	___Never
Date of Hepatitis B Vaccine				
Primary 3 shots	_____	___Unknown	___Allergic	___Never
Booster	_____	___Unknown	___Allergic	___Never
Date of MMR (measles/mumps/rubella)	_____	___Unknown	___Allergic	___Never

List any other vaccinations and date (e.g., Lyme, Hepatitis A, Varicella, etc.) _____

_____

TUBERCULOSIS SKIN TEST (PPD):

Have you ever had a positive skin test for tuberculosis? ___Yes ___No ___Unsure

If yes, was any treatment given? ___Yes (describe) _____
___No (explain) _____

Date of last PPD _____

PAST MEDICAL HISTORY **NAME:**

___Medical History not released by parent/guardian.

For information, contact: Name _____ Relation _____

Telephone # _____ Address _____

SURGICAL:

List all previous surgeries and dates (most recent first):

_____

_____

List any serious trauma or broken bones:

_____

_____

Any previous problems with anesthesia? ___No ___Yes (describe) _____

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GYNECOLOGIC (women only):
Age menstruation started _____ Age menstruation stopped _____ ___Still menstruating
Have you ever given birth to a child? ___Yes __No
Date of last PAP smear _____ ___Unknown ___Never
Any history of abnormal PAP smear? ___No ___Yes (describe) _____
Date of last mammogram _____ ___Unknown ___Never

MEDICAL: List all serious medical illnesses (e.g., pneumonia, heart attack) and ongoing medical problems (e.g., diabetes, high blood pressure, epilepsy)

_____

_____

_____

PSYCHIATRIC: List all major behavioral & psychiatric diagnoses (e.g., depression, schizophrenia, self-injurious behavior)

_____

_____

_____

Seizure History: Include description of typical seizure activity including length and frequency, list any auras or triggers and describe what is typical behavior after the seizure.

_____

_____

_____

_____

PRIOR EVALUATIONS: Please attach

Date of last Audiological Exam	_____	___Unknown	___Never
Date of last Eye Exam	_____	___Unknown	___Never
Date of last Dental Exam	_____	___Unknown	___Never
Date of last Bone Densitometry (checks bone thickness)	_____	___Unknown	___Never
Date of last Sigmoidoscopy or Colonoscopy	_____	___Unknown	___Never
Date of last PSA (Prostate Screening)	_____	___Unknown	___Never

FAMILY HISTORY

Father: Deceased: ___Yes Age at death:_____ Cause of Death:_____ ___No Current Age: _____
Mother: Deceased: ___Yes Age at death: _____ Cause of death: _____ ___No Current Age: _____

List all brothers and sisters with information about their age and health:
_____
_____

Is there a family history of:

DIABETES	___Unknown	___NO	___Yes
HIGH BLOOD PRESSURE	___Unknown	___NO	___Yes
HIGH CHOLESTEROL	___Unknown	___NO	___Yes
HEART DISEASE	___Unknown	___NO	___Yes
OSTEOPOROSIS	___Unknown	___NO	___Yes
COLON POLYPS	___Unknown	___NO	___Yes
CANCER	___Unknown	___NO	___Yes

What type? _____

Are there any other diseases that run in the family:
___Unknown ___No ___Yes (give details)
_____
_____

Has there been any genetic counseling in the family?
___Unknown ___NO ___Yes (give details)
Result_____
_____

OR-FM-HS-MA-03(10-30-09)