MEDICAL HISTORY FORM

Date: ________________ SSN: ____________________________

Participant: ____Sex: _____
Last First Middle

Medical Diagnosis:

1. _______________ 2. ________________ 3.________________ 4.__________________

Primary Doctor: ___________________________________ Phone: _____________________

Address: ____

Secondary Doctor: _________________________________ Phone: _____________________

Address: ____

Allergies:
To Medications: ____
To Foods: ____

Last seen by physician: ____

Reason for physician visit: ____

Number of doctor visits in the past year? ____

Number of days spent in the hospital in the past year?
____

Special Diet? ____

Insurance: _____ Medicare _____ Medicaid _____ Insurance Supplement

Participant: ____Sex: _____
Last First Middle

Current Medical Status

Weight: ______ Height: ______
Eyesight: ___ Good ___ Fair___ Poor

Glasses: __ Yes __ No ___ Need

Hearing: __ Good __ Fair __ Poor

Hearing Aid: __ Yes (L/R/B) __ No __ Need (L/R/B)

Teeth: _______ Own _______ Edentulous _______Dentures (Upper/ Lower/Need)

Ambulation: _______ Self _______ Cane _______W/C _______ Walker
_______Stand-by Assistance

Transfer: _______ Self _______ Assist x1 _______ Assist x2
_______ Unable to bear weight

Health Conditions: (Past or Present)

	Yes	No	Comments
Alcohol/Substance Abuse			______________________________
Alzheimer's or other dementia			______________________________
Anemia/bleeding disorders			______________________________
Arthritis/rheumatism			______________________________
Bladder: Continent/Incontinent/ Dribbles			______________________________
Bowel: Continent/Incontinent			______________________________
Cancer or leukemia			______________________________
Cataracts			______________________________
Circulation problems			______________________________
Diabetes			______________________________
Difficulty with food, chewing			______________________________

Participant: ____ Sex: _____
Last First Middle

	Yes	No	
Emphysema: COPD, Asthma, Bronchitis			___________________________
Epilepsy/Seizure Disorder			___________________________
Falls/Recent History of			___________________________
Glaucoma			___________________________
Heart trouble, CHF			___________________________
High/low blood pressure			___________________________
Hostile: Withdrawn/Depression			___________________________
Liver disease			___________________________
Mental Retardation			___________________________
Parkinson's disease			___________________________
Skin disorders: pressure sores, Leg ulcers, burns			___________________________
Stomach: intestinal disorders (Diarrhea or constipation)			___________________________
Stroke			___________________________
Thyroid Problems			___________________________
Tuberculosis			___________________________
Urinary tract disorders			___________________________
Wanders			___________________________

Other Illness's, disabilities or injuries: ____

____

Any family history of the above-mentioned health conditions? If yes, please specify which conditions and the relationship to participant:____

____

Participant: ____ Sex: _____
Last First Middle

Current medication Dosage Frequency Doctor prescribed?

____
____
____
____
____
____
____

List surgeries: Place Date

____
____
____
____

List other non-surgical hospitalizations:

Reason Place Date

____
____
____
____

Are any of the following in effect?

Power of Attorney: Yes/No
Legal Guardianship: Yes/No
Living Will: Yes/No
DNR: Yes/No

If yes to any of the above legal documents please provide a copy for our records.

Program Nurse: ________________________________ **Date:** ____________________