**ADULT PERSONAL HEALTH RECORD AND MEDICAL HISTORY**

**ALLERGIES:**

***Bring this form with you each time you visit your Health Care Professional***

Patient Name Phone ( ) (Last) (First) (Middle)

Address (Street) (City) (State) (Zip Code)

Date of Birth: Month Day Year

Gender: Male Female

Ethnicity

Social Security #

### HEALTH INSURANCE INFORMATION:

**MEDICAID #**

Name of Medicaid HMO

HMO ID#

Name & phone number of Medicaid HMO Care Manager (If known)

**MEDICARE** (if applicable)

Medicare # Medicare Part D Drug Plan

Name of Medicare Advantage HMO (if applicable)

**PRIVATE HEALTH INSURANCE (**if applicable)

Provider

### GUARDIANSHIP

Self Other If Other, please List:

Insurance ID #

Guardian’s Name Phone ( )

Address (Street) (City) (State) (Zip Code)

### HAS A LIVING WILL No

Yes

Location

**HEALTH CARE PROXY** Name Phone ( )

### CASE MANAGEMENT

Agency Phone ( )

Address (Street) (City) (State) (Zip Code)

### EMERGENCY CONTACT Relationship

**Name** Phone ( ) Phone ( )

Address (Street) (City) (State) (Zip Code)

### NEXT OF KIN Relationship

Name Phone ( ) Phone ( )

Address (Street) (City) (State) (Zip Code)

### PRIMARY CARE PHYSICIAN

Name Phone ( ) Address

(Street) (City) (State) (Zip Code)

### DENTIST

Name Phone ( ) Address

(Street) (City) (State) (Zip Code)

### PHARMACY

Name Phone ( ) Address

(Street) (City) (State) (Zip Code)

### SPECIALIST PHYSICIAN

1. Name Phone ( ) Address

(Street) (City) (State) (Zip Code)

1. Name Phone ( ) Address

(Street) (City) (State) (Zip Code)

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1. Name Phone ( ) Address

(Street) (City) (State) (Zip Code)

**Cause of Primary Disability:** Unknown Known

**Type of Disability:** Intellectual Disability Down Syndrome Cerebral Palsy

Spina Bifida Autism Spectrum Disorder (Please specify type)

Other (please specify)

**AMBULATION**: Independent

Cane

Walker

Wheel Chair

Braces Prosthesis

**VISION:** Glasses Legally Blind

**SEIZURE DISORDER:** Yes

No

Controlled: Yes

No

Type of seizure(s): Generalized Tonic Clonic Absence Last EEG/CT Head/MRI Brain Scan Date: Result:

### COMMUNICATION

Wears Helmet: No

Yes

Method of Communication: Speech Gesture Communication Device Signs

Other (specify) Language of Communication: English Spanish Other (specify) Hearing Problems: Yes No If yes, explain

Wears hearing aids

### PERSONAL CARE

Bladder Control: Yes No Bowel Control: Yes No

Special Diet (explain briefly)

## Dentures: Yes No

### ADULT IMMUNIZATIONS

DPT (Tetanus) Date Pneumonia Date Shingles Date

### FAMILY HISTORY

MOTHER

Name Date of Birth

Living: Yes No If deceased, cause of death

FATHER

Name Date of Birth

Living: Yes No If deceased, cause of death

**FAMILY MEDICAL HISTORY** Date Completed:

Please indicate with a check (√) family members who have had any of the following conditions:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Condition** | **Mother** | **Father** | **Sister** | **Brother** | **Grand- mother** | **Grand- father** | **Other Relative** |
| **Alcoholism** |  |  |  |  |  |  |  |
| **Alzheimer’s Disease** |  |  |  |  |  |  |  |
| **Anemia** |  |  |  |  |  |  |  |
| **Anesthesia problem** |  |  |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |
| **Birth Defects** |  |  |  |  |  |  |  |
| **Bleeding problem** |  |  |  |  |  |  |  |
| **Cancer, Breast** |  |  |  |  |  |  |  |
| **Cancer, Colon** |  |  |  |  |  |  |  |
| **Cancer, Ovary** |  |  |  |  |  |  |  |
| **Cancer, Prostate** |  |  |  |  |  |  |  |
| **Cancer, Melanoma** |  |  |  |  |  |  |  |
| **Cancer**, **ski**n **(excep**t **melanoma**) |  |  |  |  |  |  |  |
| **Cancer (not noted)** |  |  |  |  |  |  |  |
| **Depression** |  |  |  |  |  |  |  |
| **Developmental Disability** |  |  |  |  |  |  |  |
| **Diabetes**, **Typ**e 1 **(childhoo**d **onset**) |  |  |  |  |  |  |  |
| **Diabetes, Type 2 (adult onset)** |  |  |  |  |  |  |  |
| **Eczema** |  |  |  |  |  |  |  |
| **Epilepsy (seizures)** |  |  |  |  |  |  |  |
| **Genetic diseases** |  |  |  |  |  |  |  |
| **Glaucoma** |  |  |  |  |  |  |  |
| **Ha**y **feve**r **(Allergi**c **Rhinitis**) |  |  |  |  |  |  |  |
| **Hearin**g **Problem**s |  |  |  |  |  |  |  |
| **Hear**t **Diseas**e |  |  |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |  |  |
| **High cholesterol** |  |  |  |  |  |  |  |
| **Kidney diseases** |  |  |  |  |  |  |  |
| **Migraine headaches** |  |  |  |  |  |  |  |
| **Mitra**l **Valv**e **Prolaps**e |  |  |  |  |  |  |  |
| **Osteoarthritis** |  |  |  |  |  |  |  |
| **Osteoporosis** |  |  |  |  |  |  |  |
| **Rheumatoi**d **Arthriti**s |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |
| **Thyroid disorders** |  |  |  |  |  |  |  |
| **Tuberculosis** |  |  |  |  |  |  |  |
| **Other:** |  |  |  |  |  |  |  |

### PATIENT HOSPITALIZATIONS

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| **DATE** | **DIAGNOSIS/TREATMENT** | **FACILITY** |
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**CHRONIC (ongoing) MEDICAL DIAGNOSES**

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| **DATE** | **DESCRIPTION/TREATMENT** | **FACILITY** |
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**LONG TERM MEDICATIONS**

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| **Star**t **Dat**e | **Sto**p **Dat**e | **Medication** | **Dosage** | **Fre- quency** | **Medical Condition** | **Physician** |
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**PERIODIC EXAMINATIONS AND ACUTE (short-term) MEDICAL PROBLEMS**

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| **Date** | **Diagnosis** | **Bloodwork** | **Other Tests** | **Results** | **Treatment** | **Physician** |
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