

LIFETIME MEDICAL HISTORY

IDENTIFYING INFORMATION:

Name: _____ D. O. B. _____

GENDER: Male Female

RACE: _____ RELIGION: _____
HEIGHT: _____ WEIGHT: _____ DATE WEIGHT OBTAINED: _____

LIVING ARRANGEMENTS:

Community Group Living Family Living Provider Intermediate Care Facility OTHER _____

ADDRESS: _____

AGENCY NAME: _____
CONTACT PERSON: _____ PHONE: _____
COUNTY OF REGISTRATION: _____ BSU#: _____
SUPPORTS COORDINATOR: _____ PHONE: _____

LEVEL OF MENTAL RETARDATION:
 Profound Severe Moderate Mild

INSURANCE INFORMATION:

Primary: _____ Secondary: _____
Policy Number: _____ Policy Number: _____

SUBSTITUTE DECISION MAKER:

Name: _____ Phone Number: _____

FAMILY/PERSONAL CONTACT:

Primary: _____ Relationship: _____
Address: _____ Phone Number: _____

Secondary: _____ Relationship: _____
Address: _____ Phone Number: _____

Does the person have a court-appointed (legal) guardian? Yes No
Please note: If the guardian is listed above, place an asterisk (*) by the name. If not, please not the guardian's name, relationship, address, and phone number below.

Name: _____ Relationship: _____
Address: _____ Phone Number: _____

CURRENT HEALTHCARE PROVIDERS:

| | | | | | |
|---------------|--|---------------|--|-------------|--|
| PCP: | | Phone Number: | | Last Visit: | |
| Dentist: | | Phone Number: | | Last Visit: | |
| Psychiatrist: | | Phone Number: | | Last Visit: | |

List other specialists and therapists to the person's care:

| | | | |
|-------|--|------------|--|
| Name: | | Specialty: | |
| Name: | | Specialty: | |
| Name: | | Specialty: | |
| Name: | | Specialty: | |
| Name: | | Specialty: | |

ALLERGIES/SENSITIVITIES:

| | | |
|--------------------------|-----------|--|
| <input type="checkbox"/> | Drug: | |
| | Reaction: | |
| | Date: | |

| | | |
|--------------------------|-----------|--|
| <input type="checkbox"/> | Drug: | |
| | Reaction: | |
| | Date: | |

| | | |
|--------------------------|-----------|--|
| <input type="checkbox"/> | Drug: | |
| | Reaction: | |
| | Date: | |

| | | |
|--------------------------|-----------|--|
| <input type="checkbox"/> | Food: | |
| | Reaction: | |
| | Date: | |

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|--------------------------|-----------|--|
| <input type="checkbox"/> | Food: | |
| | Reaction: | |
| | Date: | |

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| <input type="checkbox"/> | Food: | |
| | Reaction: | |
| | Date: | |

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|--------------------------|--------------|--|
| <input type="checkbox"/> | Environment: | |
| | Reaction: | |
| | Date: | |

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| <input type="checkbox"/> | Environment: | |
| | Reaction: | |
| | Date: | |

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| <input type="checkbox"/> | Environment: | |
| | Reaction: | |
| | Date: | |

IMMUNIZATION HISTORY AND TESTING:

| | | | |
|-------------------------|--|----------------------------------|--|
| Tetnus/Diphtheria (tD): | | Hepatitis Vaccine: | |
| TB test (date/result): | | Hepatitis profile (date/result): | |
| Chest x-ray: | | Varicella: | |
| Flu shot: | | Pneumovax: | |
| Other: | | Other: | |

SOCIAL/DEVELOPMENTAL HISTORY: *(Include cause of mental retardation, if known, and when delay was first noted.)*

FAMILY HISTORY:

None Known

| System | Illness/Disease | Family Relationship | Living (L) Deceased (D) |
|------------------|-----------------|---------------------|----------------------------|
| Cardiovascular | | | |
| Pulmonary | | | |
| Gastrointestinal | | | |
| Musculoskeletal | | | |
| Other Cancer | | | |
| Endocrine | | | |
| Psychiatric | | | |
| Other | | | |

SPECIAL CONCERNS: *(e.g.: must sit up 30 minutes after eating; must take C-PAP to ATF to use if he needs to nap, etc.)*

PAST MEDICAL HISTORY - HOSPITALIZATIONS:

| Admit/Discharge Date(s) | Hospital | Diagnosis/Reason/Surgery |
|-------------------------|----------|--------------------------|
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PAST MEDICAL HISTORY – PSYCHIATRIC HOSPITALIZATIONS:

| Admit/Discharge Date(s) | Hospital | Diagnosis/Reason |
|-------------------------|----------|------------------|
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