

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:	

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

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

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

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

<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

PAST MEDICAL HISTORY – PSYCHIATRIC HOSPITALIZATIONS:

Admit/Discharge Date(s)	Hospital	Diagnosis/Reason

