Medical Information Form

(to be completed by the applicant or caregiver)

Date_____

Person filling out this form (if not the applicant)_____

Applicant's Name_____

Address_____
Street

_____
City State Zip Code

E-mail_____

Home Phone ( )_____ Work Phone ( )_____

Cell Phone ( )_____

Date of Birth _____ Sex M___ F___
M D Y

Social Security # _____

Marital status _____

In an emergency, contact:

Name_____

Relationship_____

Phone (Home)_____

(Work)_____

(Cell)_____

Primary Care Physician:

Name_____

Phone_____

Fax_____

Socioeconomic

Occupation_____ Retired____ Active____

Marital Status (Please circle you *current status*)

Single Significant Other Married Divorced Other

Spouse or significant other's name_____

Living Quarters (Please circle your *current status*)

House Apartment Assisted Living Personal Care

Numbers of floors in your house or apartment?_____

Do you live alone? Yes____ No____

If no, whom do you live with?_____

Do you drive a car? Yes____ No____

If no, who drives you?_____

Are you an organ donor? Yes____ No____

What is the highest level of education that you received?_____

Medical History

Have you ever had a stroke? Yes____ No_____

If yes, please list the dates of all strokes_____

_____

What type of stroke(s) did you have? A bleed or a clot? _____

_____

Have you ever had a seizure? Yes____ No____

If yes, what was the date of your last seizure?_____

Are you currently taking medication for seizures? Yes____ No____

Do you have hypertension? Yes____ No____

If yes, are you currently being treated for hypertension? _____

_____

Have you ever had a heart attack? Yes____ No____

If yes, please list the dates of all heart attacks_____

_____

Do you have congestive heart failure? Yes____ No____

If yes, are you currently being treated for congestive heart failure?__

_____

Do you have chronic obstructive pulmonary disease (COPD)?

Yes____ No____

If yes, are you currently being treated for COPD?_____

_____

Do you have diabetes? Yes____ No____

If yes, are you currently being treated for diabetes?_____

_____

What other medical problems do you have?_____

_____

_____

_____

What surgeries have you had?_____

_____

_____

_____

Please list all of your prescriptions, non-prescription and herbal medications:

Name	Dose	Directions

Name	Dose	Directions

If you have any allergies or “bad reactions” to any medications, please list them:

1. _____
2. _____
3. _____

Other allergies (please circle)

Hay Fever Food Hives IVP dye Asthma

Other_____

Please indicate below whether you have had any of the following symptoms within the last 30 days.

Constitutional	Yes	No	Comments
Fatigue, Tiredness			
Change in weight			
Fever, chills or sweats			

Constitutional	Yes	No	Comments
Pain on most days			

Eyes	Yes	No	Comments
Vision loss, impairment			
Inflammation of eyes			
Pain, blurring, double vision or dry eyes			
Dry eyes			

Ears/Nose/Mouth/Throat	Yes	No	Comments
Poor hearing			
Earaches or ringing in ears			
Nosebleeds			
Problem chewing or swallowing			
Hoarseness or change in voice			

Cardiovascular	Yes	No	Comments
Chest pain or pressure			
Palpitations			
History of heart murmur			
Swelling of feet			

Respiratory	Yes	No	Comments
Shortness of breath at rest			
Shortness of breath on exertion			
Cough (if yes, do you bring up phlegm? what color?			

Respiratory	Yes	No	Comments
Wheezing			
Sleep apnea			

Gastrointestinal	Yes	No	Comments
Recent change in appetite			
Nausea or vomiting			
Indigestion			
Diarrhea or constipation			
Hemorrhoids			
Abdominal pain			
Blood or mucus in stool			
Losing control of bowels			

Genitourinary	Yes	No	Comments
Increased frequency of urination			
Burning or pain on urination			
Waking up to urinate			
Frequent urinary tract infections			
Loss of control of urine			

Musculoskeletal	Yes	No	Comments
Problems with walking or balance			
Recent falls			
Muscle pain or swelling			
Back or neck pain			

Psychiatric	Yes	No	Comments
Problems with sleeping			
Sadness much of the time			
Worried most of the time			

Endocrine	Yes	No	Comments
Fatigue			
Excessive thirst			
Excessive hunger			

Neurological	Yes	No	Comments
Headaches			
Weakness			
Tremors			
Numbness or tingling			
Problems with memory			
Dizziness			
Fainting			

Skin and/or Breast	Yes	No	Comments
Rash, skin problem			
Itchiness			
Moles			

Hematological	Yes	No	Comments
Bruise easily			
Bleeding excessively			
Swollen glands or nodes			

Please answer all the following questions, even if you are not sure, and give dates if applicable.

	Yes	No	Unsure	Date of last time
Flu injection				
Pneumonia vaccine				
Zoster vaccine				
Tetanus vaccine				
Stool, tested for blood				
Colonoscopy				
Blood test for cholesterol				
Bone density scan				
TB (tuberculosis) skin test				
Chest X-Ray				
CAT scan				
Recent X-Rays (past 12 months)				
Thyroid test				
Electrocardiogram (EKG)				
Stress test				
Cardiac catherization				
MRI scans				

Have you had any blood work or lab studies done recently? _____

If yes, give dates and places were studies were done. Please include results, if known_____

_____

_____

Are you assisted with any of the following?

	No	A little assistance	A lot of assistance
Feeding self			
Bathing			
Dressing			
Using the toilet			
Getting out of bed or chair			
Shopping for groceries			
Preparing meals			
Housework (laundry, cleaning, etc)			
Taking your medications (Does someone remind you?)			
Managing your money			
Walks in your residence			
Accompanying yourself when you leave your residence			

Are there any other personal needs that you need assistance with? _____

_____

_____

Assistive Devices

	Yes	No
Do you wear hearing aids?		
Do you wear eye glasses? If yes, what was the date of your last exam?_____		
Do you wear partials or dentures?		

	Yes	No
Do you use a cane or walker? If yes, please list_____		
Do you use a wheelchair? If yes, are you able to independently transfer yourself from your wheelchair to another chair or bed?_____ _____		

Social History

Tobacco:

Have you ever smoked? Yes____ No____

If yes, how many packs a day? ____

How many years have you been smoking?____

Other tobacco products: (Please circle those that apply to you)

Pipe Snuff Cigar Chew Other_____

If you have stopped smoking, please give the date_____

Alcohol:

Do you drink alcohol? Yes____ No____

Please circle all that apply: Wine Beer Hard Liquor

If yes, approximately how many ounces a week?_____

Are you on a special diet?_____ If yes, please describe_____

_____

Do you exercise?_____If yes, please describe_____

_____