Health History Information

New Hampshire Bureau of Developmental Services

Completed By:
Relationship to Individual:
Date:

To be completed at the Service Agreement and updated annually, as well as after any major illnesses, surgeries, or changes.

Name____ **Likes to be called**_______________________________________

D.O.B. _______________ **Soc. Sec #** ______________________ **Religion:**____

Address____

____

Tel. # ____

Health Insurance (type & numbers)

Primary:______________________________________

Secondary:____________________________________

Agency Responsible for Providing Care:____ **Tel. #**__________________________

Agency primary contact person:____ **Tel. #**__________________________

Consent Status: ☐ Can give own consent ☐ **Unable to give own consent and no guardian**

☐ Consent from guardian(s) ☐ Name_______________________________________ Tel. #__________________

Resuscitation Status: ☐ Full Resuscitation ☐ Name_______________________________________ Tel. #__________________

☐ DNR If DNR is comfort care form available? ☐ Yes ☐ No ☐ Unknown

Emergency Contacts

#1 Name ____

Tel. ___________________

#2 Name ____

Tel. ___________________

MEDICATIONS: ☐ Medication sheet/record attached

Or ☐ List attached, including dose, route, frequency, and reason given.

Pharmacy: Name: ___________________Tel: ______________

Address: ____

Allergies: Medications: ______________________________

Food/Environment: ______________________________

Type of Reaction: _________________________________

Current Medical Problems & Diagnoses: ________________

____

____

____

____

Communication
- ☐ Able to communicate
- ☐ Communication difficulties/Uses verbalizations
- ☐ Communication difficulties/Uses gestures
- ☐ Not able to communicate needs
- ☐ Unable to use call bell
- ☐ Needs assistance to communicate needs

Vision
- ☐ Normal
- ☐ Low Vision
- ☐ Blind
- ☐ Wears glasses

Hearing
- ☐ Normal
- ☐ Hard of hearing
- ☐ Deaf
- ☐ Hearing aid

Supportive Devices
- ☐ Padded side rails

Toileting Ability
- ☐ Continent

Medication Administration
- ☐ Independent/Self medicated
- ☐ Medication administered by staff

Dining/Eating
- ☐ Independent
- ☐ Needs assistance
- ☐ Must be supervised/at risk for choking
- ☐ Totally dependent
- ☐ Fed through a tube
- ☐ Other________

Diet Texture
- ☐ Regular
- ☐ Chopped
- ☐ Ground

Ambulation
- ☐ Independent ☐ Steady ☐ Unsteady
- ☐ Needs assistance ☐ 1 person ☐ 2 person
- ☐ Needs aids ☐ Walker ☐ Cane ☐ Crutches
- ☐ Wheelchair
- ☐ Non-ambulatory

Personal Hygiene
- ☐ Independent
- ☐ Special needs________

Oral Hygiene
- ☐ Independent
- ☐ Special needs________

Head of Bed Elevated

Special Needs

Usual Response to Medical Exams: ☐ Cooperates ☐ Partially cooperates ☐ Resistant ☐ Fearful

☐ Sedation for clinical visits (Explain):____

☐ Special Positioning required for examination (Explain):____

☐ Double staffing required for assistance with exams (Explain):____

☐ Requires limited waiting periods for exams

☐ Prefers early day appointments ☐ Prefers end of day appointments

☐ Special communication device/method examination (Explain):____

Pain Response ☐ Normal ☐ Unique (Explain):____

MEDICAL PROVIDERS **NAME:**

Primary Care	**Subspecialist/Type:**
Name________________ Tel # __________ Address____________________ ____________________	Name________________ Tel # __________ Address____________________ ____________________
Dental Care	**Subspecialist/Type:**
Name________________ Tel # __________ Address____________________ ____________________	Name________________ Tel # __________ Address____________________ ____________________
Eye Care	**Subspecialist/Type:**
Name________________ Tel # __________ Address____________________ ____________________	Name________________ Tel # __________ Address____________________ ____________________
Subspecialist/Type:	**Subspecialist/Type:**
Name________________ Tel # __________ Address____________________ ____________________	Name________________ Tel # __________ Address____________________ ____________________

Living Status: ▫ Group Home ▫ Own Family ▫ Independent ▫ Home Sharing/Shared Home

▫ Other __________________

Contact name/number (if applicable) of home care provider/group home manager: ____________________

____

Marital Status: ▫ Single ▫ Married ▫ Other _______

Nursing Supports available:

▫ In home ▫ In home 24 hr

▫ Nursing Coordination ▫ Access to VNA

▫ No Nursing supports

Work/Day Program Status:

▫ Community Day Support

▫ Regular job ▫ Sheltered workshop

IMMUNIZATIONS

Date of last TETANUS ____________________ ▫ Unknown ▫ Allergic ▫ Never

Date of last FLU SHOT ____________________ ▫ Unknown ▫ Allergic ▫ Never

Date of last PNEUMOVAX ____________________ ▫ Unknown ▫ Allergic ▫ Never

Date of HEPATITIS B VACCINE

Primary Series (3 Shots) ____________________ ▫ Unknown ▫ Allergic ▫ Never

Date of MEASLES/MUMPS/RUBELLA ____________ ▫ Unknown ▫ Allergic ▫ Never

List any other vaccinations and date (e.g., Lyme, Hepatitis A, Varicella, etc.)

____

TUBERCULOSIS SKIN TEST (PPD):

Have you ever had a positive skin test for tuberculosis? ▫ Yes ▫ No ▫ Unsure

If Yes, was any treatment given? ▫ Yes (Describe) ____________________

▫ No (Explain) ____________________

Date of last PPD _________

Weight:_______________Compared to previous year:____________________________

Major illness, surgeries, or changes in past year:____________________________________

____

Smoke: ▫ No ▫ Yes amt:_______________________**ETOH/drug:** ▫ No ▫ Yes amt:_______________________

Hx of eating disorder: □ No □ Yes descrube:____

PAST MEDICAL HISTORY **NAME:**

□ **Medical History not released by parent/guardian.**

For information, contact: Name ________________________________ Relation ___________________________

Tel # ______________________ Address ____

SURGICAL:

List all previous surgeries and dates (most recent first):

____

____

____

List any serious trauma or broken bones:

____

____

____

Any previous problems with anesthesia? □ No □ Yes (describe)

GYNECOLOGIC (women only):

Age menstruation started ______________________ Age menstruation stopped ________________________ □ Still menstruating

Have you ever given birth to a child? □ Yes □ No

Date of last PAP smear __________________ □ Unknown □ Never

Any history of abnormal PAP smear? □ No □ Yes (describe) ____

MEDICAL: List all serious medical illnesses (e.g., pneumonia, heart attack) and ongoing medical problems (e.g., diabetes, high blood pressure, epilepsy)

____

____

____

____

____

PSYCHIATRIC: List all major behavioral & psychiatric diagnoses (e.g., depression, schizophrenia, self-injurious behavior)

____

____

____

____

____

PRIOR EVALUATIONS:

Date of last AUDIOLOGICAL EXAM ____ □ Unknown □ Never

Date of last EYE EXAM ____ □ Unknown □ Never

Date of last DENTAL EXAM ____ □ Unknown □ Never

Date of last BONE DENSITOMETRY (checks bone thickness) _____________________ □ Unknown □ Never

Date of last SIGMOIDOSCOPY or COLONOSCOPY _________________________ □ Unknown □ Never
(scope examination of large intestine)

Date of last PSA (prostate cancer screening) (men only) □ Unknown □ Never

FAMILY HISTORY

FATHER: Deceased? □ Yes Age at death: ______________
Cause of death: ______________
□ No Current Age: ______________

MOTHER: Deceased? □ Yes Age at death: ______________
Cause of death: ______________
□ No Current Age: ______________

Is there any family history of:

DIABETES	□ Unknown	□ No	□ Yes
HIGH BLOOD PRESSURE	□ Unknown	□ No	□ Yes
HIGH CHOLESTEROL	□ Unknown	□ No	□ Yes
HEART DISEASE	□ Unknown	□ No	□ Yes
OSTEOPOROSIS	□ Unknown	□ No	□ Yes
COLON POLYPS	□ Unknown	□ No	□ Yes

List all brother and sisters with information about their age and health:

____

____

____

____

____

Are there any other diseases that "run in the family?"

□ Unknown □ No □ Yes (give details below)

____

____

____

Has there been any genetic counseling in the family?

□ Unknown □ No □ Yes (give details below)

Result: