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_____

_____

Health Insurance (type & numbers)

Primary:_____

Secondary:_____

Tel. # _____

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
Advanced Directives: ☐ No ☐ Yes Name_____ Tel. #_____

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
☐ Splints
☐ Braces
☐ Helmet
☐ Other _____

Toileting Ability
☐ Continent
☐ Needs Assistance
☐ Incontinent
☐ Catheterized
☐ Other_____

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
☐ Puree
☐ Thicken liquid

Diet type_____
_____

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
☐ Yes
☐ No

Adaptive Equipment ☐ Yes ☐ No
If yes, describe:_____

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):_____

Primary Care	**Subspecialist/Type:**
Name_____ Tel # _____	Name_____ Tel # _____
Address_____	Address_____
_____	_____
Dental Care	**Subspecialist/Type:**
Name_____ Tel # _____	Name_____ Tel # _____
Address_____	Address_____
_____	_____
Eye Care	**Subspecialist/Type:**
Name_____ Tel # _____	Name_____ Tel # _____
Address_____	Address_____
_____	_____
Subspecialist/Type:	**Subspecialist/Type:**
Name_____Tel # _____	Name_____Tel # _____
Address_____	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 _____

Work/Day Program Status:
☐ Community Day Support
☐ Regular job ☐ Sheltered workshop

Nursing Supports available:
☐ In home ☐ In home 24 hr
☐ Nursing Coordination ☐ Access to VNA
☐ No Nursing supports

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 describe:_____

☐ **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) _____

Date of last mammogram _____ ☐ Unknown ☐ Never

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
CANCER	☐ Unknown	☐ No	☐ Yes

What type? _____

_____

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: _____

_____