 **HEALTH LIST**

FIRST NAME LAST NAME DATE OF BIRTH

Address City State Zip

Residence Main Phone# Alternate or Cell Phone #

MEDICAID # Insurance Name and #

MEDICARE # MEDICARE PART B #

GENDER

HEIGHT FEET

INCH

WEIGHT

POUNDS

RACE

HAIR EYES

Does the person have an Advance Directive? If YES, Date of the Advanced Directive?

Describe Advance Directive

Does the person have a Support Person?

**ANY KNOWN FOOD, DRUG OR ENVIRONMENTAL ALLERGIES?**

**List Allergies Here**

**SUPPORT TEAM CONTACT INFORMATION**

PROVIDER AGENCY NAME Agency Phone #

PROVIDER AGENCY CONTACT NAME Contact Phone #

Address

City

State Zip

DDA SERVICE COORDINATOR NAME DDA Contact Phone #

# PRIMARY HEALTH PROVIDERS

**PCP** NAME Office Phone #

Address City State Zip

SENSORY DEFICITS

ADAPTIVE EQUIPMENT

COGNITIVE SKILL LEVEL ADAPTIVE SKILL LEVEL

MOBILITY STATUS RELATED EQUIPMENT

COMMUNICATION EXPRESSES PAIN BY

ENTERAL NUTRITION?

POSITION PROTOCOL?

MEAL PROTOCOL?

DIET TEXTURE FOOD INTOLERANCE

PERSON HAS A BEHAVIOR SUPPORT PLAN BEHAVIORS OF CONCERN/TRIGGERS

OTHER ADAPTIVE EQUIPMENT

# MEDICAL INFORMATION

|  |  |
| --- | --- |
| Start Date | LIST CURRENT MEDICAL PROBLEMS, SURGICAL HISTORY, ANY SPECIAL TREATMENTS |
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| --- | --- | --- | --- | --- |
| Start Date | Medication Name | Dosage | Frequency | To Treat? |
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**DATES OF IMMUNIZATIONS & RELATED TESTS**

INFLUENZA (FLU) PPD (TUBERCULOSIS)

# OTHER COMMENTS OR INFORMATION

**A signature is required with each update to ensure all information is current.**

|  |  |  |
| --- | --- | --- |
| Date of Update | Printed Name | Signature |
|  |  |  |
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Save Form As

Print Form