GEORGETOWN UNIVERSITY

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 | WEIGHT | RACE | HAIR | EYES

FEET | INCH | POUNDS

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 | ADAPTIVE

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

Start Date	Medication Name	Dosage	Frequency	To Treat?

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

Save Form As Print Form