



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 _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____

Primary Care Physician:

Name _____

Phone _____

Fax _____

Socioeconomic

Occupation _____ Retire _____ Active _____

Marital Status (Please circle your *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

Number of floors in your house/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? _____

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 or stroke(s) did you have? A bleed or 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 (if any) do you have? _____

What surgeries have you had? List dates if available _____

Do you have a pacemaker or other implanted device?

Yes _____ No _____

Do you have any shrapnel or scrap metal in your body?

Yes _____ No _____

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

Name	Dose	Directions

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, Ringing in Ears			
Nosebleeds			
Problems Chewing/Swallowing			
Hoarseness or Changes 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?)			
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			
Loss of Control of Bowels			
Genitourinary	Yes	No	Comments
Increased Frequency of Urination			
Burning or Pain during 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 Problems			
Itchiness			
Moles			
Hematological	Yes	No	Comments
Bruise easily			
Bleeding excessively			
Swollen Glands or Nodes			

Please answer 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? Yes _____ No _____

If yes, give dates and places where studies were done. Please include results, if known. _____

	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			
Walking in Your Residence			
Accompanying yourself when you Leave your Residence			

Are there any other personal needs that you need assistance with? If yes, please list them.

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?		
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 into 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? _____

If you have stopped smoking, please give the date _____

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

Pipe Snuff Cigar Chew Other _____

Alcohol:

Do you drink alcohol? Yes _____ No _____

Please circle all that apply: Wine Beer Hard Liquor

If yes, approximately how many ounces a week? _____

Dietary:

Are you on a special diet? Yes _____ No _____

If yes, please describe _____

Do you exercise? Yes _____ No _____

If yes, please describe type of exercise and frequency _____