

ADULT PERSONAL HEALTH RECORD AND MEDICAL HISTORY



ALLERGIES:

Patient Name _____ Phone () _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip Code)

Date of Birth: Month ____ Day ____ Year ____ Gender: Male ____ Female ____ Ethnicity _____

Social Security # _____

HEALTH INSURANCE INFORMATION:

MEDICAID/Medicare # _____

PRIVATE HEALTH INSURANCE (if applicable)

Provider _____ Insurance ID # _____

GUARDIANSHIP

Self ____ Other ____ If Other, please List:

Guardian's Name _____ Phone () _____

Address _____
(Street) (City) (State) (Zip Code)

HAS A LIVING WILL No ____ Yes ____ Location _____

HEALTH CARE PROXY Name _____ Phone () _____

CASE MANAGEMENT

Agency _____ Phone () _____

Address _____
(Street) (City) (State) (Zip Code)

EMERGENCY CONTACT Relationship _____

Name _____ Phone () _____ Phone () _____

Address _____
(Street) (City) (State) (Zip Code)

Cause of Primary Disability: Unknown _____ Known _____

Type of Disability: Intellectual Disability _____ Down Syndrome _____ Cerebral Palsy _____
Spina Bifida _____ Autism Spectrum Disorder (Please specify type) _____
Other (please specify) _____

AMBULATION: Independent _____ Cane _____ Walker _____ Wheel Chair _____
Braces _____ Prosthesis _____

VISION: Glasses _____ Legally Blind _____

SEIZURE DISORDER: Yes _____ No _____ Controlled: Yes _____ No _____

Type of seizure(s): Generalized _____ Tonic _____ Clonic _____ Absence _____

Last EEG/CT Head/MRI Brain Scan Date: _____ Result: _____

Wears Helmet: No _____ Yes _____

COMMUNICATION

Method of Communication: Speech _____ Gesture _____ Communication Device _____ Signs _____
Other (specify) _____

Language of Communication: English _____ Spanish _____ Other (specify) _____

Hearing Problems: Yes _____ No _____ If yes, explain _____

Wears hearing aids _____

PERSONAL CARE

Bladder Control: Yes _____ No _____ Bowel Control: Yes _____ No _____

Special Diet (explain briefly) _____

Dentures: Yes _____ No _____

ADULT IMMUNIZATIONS

DPT (Tetanus) Date _____ Pneumonia Date _____ Shingles Date _____

FAMILY HISTORY

MOTHER

Name _____ Date of Birth _____

Living: Yes _____ No _____ If deceased, cause of death _____

FATHER

Name _____ Date of Birth _____

Living: Yes _____ No _____ If deceased, cause of death _____

FAMILY MEDICAL HISTORY

Date Completed: _____

Please indicate with a check (√) family members who have had any of the following conditions:

Medical Condition	Mother	Father	Sister	Brother	Grand-mother	Grand-father	Other Relative
Alcoholism							
Alzheimer's Disease							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Ovary							
Cancer, Prostate							
Cancer, Melanoma							
Cancer, skin (except melanoma)							
Cancer (not noted)							
Depression							
Developmental Disability							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy (seizures)							
Genetic diseases							
Glaucoma							
Hay fever (Allergic Rhinitis)							
Hearing Problems							
Heart Disease							
High Blood Pressure							
High cholesterol							
Kidney diseases							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other:							

