# CURRENT PERSONAL SUMMARY – page 1

Information current as of (date):_____ (See back for medical history)

**NAME: _____**Likes to be called: _____ D.O.B. _____

Address: _____ Home Phone: _____

Primary Contact Name and Phone:_____

Emergency Contact Information: _____

Guardian Info: _____

Primary Physician and Phone:_____

SS#:_____ Medicare #: _____
Medicaid #: _____ Other Insurance:_____

Ht_____ Wt_____ Blood Type_____ **ALLERGIES or SENSITIVITIES: NO❑ YES❑ Specify:**
_____
_____
_____

**Chronic Diagnoses:_____**
**_____**
**_**

**Level of mental retardation**: Mild ❑ Moderate ❑ Severe ❑ Profound ❑ Other DD:_____

**Functional Status**: Impaired Vision❑ Blind❑ Impaired Hearing ❑ Deaf ❑ Other: _____

**Communication:** Easily Understood❑ Difficult to Understand ❑ Nonverbal <u>but</u> understands some ❑
Signs with Standard Sign Language ❑ Signs -Uses Own Gestures❑ No Receptive or Expressive lang ❑

**Residential Supervision**: ❑24 HR ❑Specify number of staffing hours per **Day** ❑_____or ❑**Week**_____

**Care Limitations** (includes ability to take meds): _____
Self-Administering Meds❑ _____
Assistance w/Self Administering Meds❑ _____
Medication Provided by Unlicensed Worker ❑ _____

**Assistance with daily needs:** Meds❑ Eating❑ Dressing❑ Toileting❑ Bathing❑ Dental Care❑

**Adaptive Equipment**: Glasses ❑ Hearing Aid❑ Trach ❑ G/J Tube ❑ Oxygen ❑ Cane ❑
Walker ❑ Prosthesis ❑ Wheelchair ❑ Communication Device ❑ Other:_____

**Seizures: NO❑ YES❑Specify Frequency/Severity**:_____

**Behavioral Issues:**

# CURRENT PERSONAL SUMMARY-page 2

**Social History**:

Tobacco qY qN PPD_____ # years:_____
Alcohol qY qN Drinks/week_____
Caffeine qY qN Cups per day_____
Illicit Drugs qY qN Type: _____

Last time you had any of the following **vaccines**: (list year)

flu vaccine ____ rubella ____
hepatitis ____ haemophilus Influenza HIB ____
pneumococcal ____ chicken pox ____
oral polio ____ measles-mumps-rubella ____
TB ____ Other:_____

**Last time you had a: (list year)**

Pneumonia Shot _____ Tetanus shot: _____
Stool Blood Test _____ TB Skin Test _____
Sigmoid exam _____ Rectal exam _____
Hearing Test _____ Eye exam _____
Cholesterol Test _____ PT evaluation ____
Dental Exam _____ Prostate test (PSA) ____

**For WOMEN ONLY:** Age of onset of menstrual period___
Sexually active qY qN Use of birth Control qY qN Type:
# of Pregnancies _____ # of live births_____
# of miscarriages_____ # of abortions _____
**Year of last:** Breast exam ____ normal__ abnormal ___
Mammogram: _____ normal _____ abnormal ____
Pap test: _____ normal _____ abnormal ____

**Family History:** (Has any blood relative-parents, brothers, sisters, aunts, uncles, grandparents, cousins) had any of the following? Check "Y" for yes and "N" for no – leave blank if uncertain:

| CONDITION | | RELATIONSHIP | CONDITION | | RELATIONSHIP |
|---|---|---|---|---|---|
| Cancer | ❑YES ❑NO | | Stroke | ❑YES ❑NO | |
| Heart Attach | ❑YES ❑NO | | Anemia | ❑YES ❑NO | |
| Coronary Artery Disease: specify age of onset____ | | | Bleeding Tendencies | ❑YES ❑NO | |
| Asthma | ❑YES ❑NO | | High Blood Pressure | ❑YES ❑NO | |
| Allergies | ❑YES ❑NO | | Rheumatoid Arthritis | ❑YES ❑NO | |
| Thyroid Disease | ❑YES ❑NO | | Mental Retardation | ❑YES ❑NO | |
| Tuberculosis | ❑YES ❑NO | | Migraine Headaches | ❑YES ❑NO | |
| Lupus | ❑YES ❑NO | | Alcohol/Drug Abuse | ❑YES ❑NO | |
| Depression | ❑YES ❑NO | | Learning Disabilities | ❑YES ❑NO | |
| Anxiety | ❑YES ❑NO | | Epilepsy | ❑YES ❑NO | |
| Suicide | ❑YES ❑NO | | Diabetes | ❑YES ❑NO | |
| Panic Attacks | ❑YES ❑NO | | | | |

**Past Medical History:** (Have you ever had the following? Check "Y" for yes and "N" for no-leave blank if uncertain: if yes, indicate in the comments section approximately when or how long)

| | | | | | |
|---|---|---|---|---|---|
| Measles ❑YES ❑NO | Migraine ❑YES ❑NO | Hives or eczema ❑YES ❑NO |
| Mumps ❑YES ❑NO | Tuberculosis ❑YES ❑NO | AIDS or HIV+ ❑YES ❑NO |
| Chicken pox ❑YES ❑NO | Diabetes ❑YES ❑NO | Infectious Mono ❑YES ❑NO |
| Whooping Cough ❑YES ❑NO | Cancer ❑YES ❑NO | Bronchitis ❑YES ❑NO |
| Scarlet Fever ❑YES ❑NO | Glaucoma ❑YES ❑NO | Mitral Valve Prolapse ❑YES ❑NO |
| Diptheria ❑YES ❑NO | Polio ❑YES ❑NO | Stroke ❑YES ❑NO |
| Smallpox ❑YES ❑NO | Hernia ❑YES ❑NO | Hepatitis ❑YES ❑NO |
| Pneumonia ❑YES ❑NO | Stomach Ulcer ❑YES ❑NO | Blood Transfusion ❑YES ❑NO |
| Rheumatic fever ❑YES ❑NO | Back Trouble ❑YES ❑NO | Kidney Disease ❑YES ❑NO |
| Arthritis ❑YES ❑NO | Hemorrhoids ❑YES ❑NO | Bleeding Tendencies ❑YES ❑NO |
| Anemia ❑YES ❑NO | Epilepsy ❑YES ❑NO | Bladder Infections ❑YES ❑NO |

**List any other diseases:**
Comments:

**Hospitalizations:**

| Year | Illness/Operation |
|---|---|
| ____ | _____ |
| ____ | _____ |
| ____ | _____ |
| ____ | _____ |
| ____ | _____ |

**Previous Diagnostics (attach results, if available**)

| | | Date: |
|---|---|---|
| EKG | ❑YES ❑NO | _____ |
| EEG | ❑YES ❑NO | _____ |
| Brain CT scan | ❑YES ❑NO | _____ |
| Brain MRI | ❑YES ❑NO | _____ |
| Echocardiogram | ❑YES ❑NO | _____ |