# 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:**__________________________________________________________________

_____________________________________________________________________________________

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**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 but 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 | ☐YES ☐NO | PPD______ # years:______ |
| Alcohol | ☐YES ☐NO | Drinks/week______________ |
| Caffeine | ☐YES ☐NO | Cups per day_____________ |
| illicit Drugs | ☐YES ☐NO | Type: ___________________ |

**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) | ____ |

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:___________________________ | |

**For WOMEN ONLY:** Age of onset of menstrual period___
Sexually active ☐YES ☐NO Birth Control ☐YES ☐NO 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 |
|---|---|---|---|
| Cancer | ❑YES | ❑NO | |
| Heart Attach | ❑YES | ❑NO | |
| Coronary Artery Disease: specify age of onset____ | | | |
| Asthma | ❑YES | ❑NO | |
| Allergies | ❑YES | ❑NO | |
| Thyroid Disease | ❑YES | ❑NO | |
| Tuberculosis | ❑YES | ❑NO | |
| Lupus | ❑YES | ❑NO | |
| Depression | ❑YES | ❑NO | |
| Anxiety | ❑YES | ❑NO | |
| Suicide | ❑YES | ❑NO | |
| Panic Attacks | ❑YES | ❑NO | |

| CONDITION | | | RELATIONSHIP |
|---|---|---|---|
| Stroke | ❑YES | ❑NO | |
| Anemia | ❑YES | ❑NO | |
| Bleeding Tendencies | ❑YES | ❑NO | |
| High Blood Pressure | ❑YES | ❑NO | |
| Rheumatoid Arthritis | ❑YES | ❑NO | |
| Mental Retardation | ❑YES | ❑NO | |
| Migraine Headaches | ❑YES | ❑NO | |
| Alcohol/Drug Abuse | ❑YES | ❑NO | |
| Learning Disabilities | ❑YES | ❑NO | |
| Epilepsy | ❑YES | ❑NO | |
| Diabetes | ❑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 | ____________ |