

Organization Name:	Program Name:	Date:
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Individual's Name (First MI Last):	Record #:	DOB:
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SUMMARY LIST

Significant Medical Diagnoses and Conditions	Check One		Currently Under a Doctor's Care	Comment
	Now	Past		
Alzheimer's Disease or Dementia	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Sugar-High	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Pressure (High)	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Deafness or other hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	<input type="checkbox"/>	<input type="checkbox"/>		
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		
Hyperlipidemia (High blood fat/Cholesterol and/or Triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>		
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	<input type="checkbox"/>	<input type="checkbox"/>		
Mobility Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Other Cardiac Condition	<input type="checkbox"/>	<input type="checkbox"/>		
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	<input type="checkbox"/>	<input type="checkbox"/>		
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>		



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Sight Impairment	<input type="checkbox"/>	<input type="checkbox"/>			
Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Weight (Obesity, Unexplained Gain or Loss)	<input type="checkbox"/>	<input type="checkbox"/>			
Other physical related health conditions	<input type="checkbox"/>	<input type="checkbox"/>			
Other:	<input type="checkbox"/>	<input type="checkbox"/>			
Other:	<input type="checkbox"/>	<input type="checkbox"/>			
Other:	<input type="checkbox"/>	<input type="checkbox"/>			
Other:	<input type="checkbox"/>	<input type="checkbox"/>			
Other:	<input type="checkbox"/>	<input type="checkbox"/>			

Medical hospitalizations/significant operative and invasive procedures?

No Yes If yes, complete information below.

Hospital	Date	Reason



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Medication List

List all medications individual in care is taking including medications prescribed by this provider, medications prescribed by outside prescribers as well as herbal remedies, vitamins, nutraceuticals, or over-the-counter drugs.

Date	Medication	Dosage / Route / Frequency	Supply: Amount / Refills	Status	Purpose	Rationale for Change	Name of Prescriber	Source of Knowledge
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report
				<input type="checkbox"/> New/Adj. <input type="checkbox"/> Continue <input type="checkbox"/> Discont.				<input type="checkbox"/> Prescriber <input type="checkbox"/> Outside Prescriber <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual Self-Report

ALERTS- Medication Allergy/Adverse Events: