



HEALTH RECORD

Massachusetts Department of Developmental Services

(1) Entry Date: _____
(2) Entered By: _____

(To be completed or updated at the ISP and brought to all new medical contacts)

BASIC INFORMATION

(3) Name: _____ (13) Likes to be called: _____

(4) D.O.B: _____ (5) Gender: _____ (6) SSN: _____ (14) Religion: _____

(7) Address Line 1: _____ **Health Insurance (type & numbers)**

(8) Address Line 2: _____ (15A) Ins. #1: _____ (15B) #: _____

(9) City: _____ (10) State: _____ (11) Zip: _____ (16A) Ins. #2: _____ (16B) #: _____

(12) Telephone: _____ (17A) Ins. #3: _____ (17B) #: _____

(18A) Ins. #4: _____ (18B) #: _____

(19) Agency Responsible for Provider Care? No Yes (19A) _____ (19B) Tel. #: _____
Name of agency/primary contact person

(20) Consent Status: Can give own consent Consent from guardian Unable to give own consent and no guardian
(20A) If Consent from Guardian, Guardian Name: _____ (20B) Tel. #: _____

(21) Resuscitation Status: DNR Full Resuscitation (21A) If DNR is comfort care available? Yes No Unknown

(22) Is there a MOLST form in place? Yes No Unknown

(23) Health Care Proxy: Yes No Unknown (23A) Name: _____ (23B) Tel. #: _____

(24) Additional Comment regarding the individual's medical condition or state: _____

CONTACTS – EMERGENCY AND PHARMACY (Repeat 25A – 25I for additional emergency/pharmacy contacts on separate sheet)

(25A) Type <i>Select One</i>	Priority (25B)	Name (25C)	(25D) Street Address	(25E) City	(25F) State	(25G) Zip	(25H) Telephone	(25I) Fax
<input type="checkbox"/> Emergency <input type="checkbox"/> Pharmacy								
<input type="checkbox"/> Emergency <input type="checkbox"/> Pharmacy								
<input type="checkbox"/> Emergency <input type="checkbox"/> Pharmacy								
<input type="checkbox"/> Emergency <input type="checkbox"/> Pharmacy								

MEDICATIONS LIST

(Repeat 26A – 26F for additional medications on separate sheet)

Frequency Options:

- 1 x day
- 2 x day
- 3 x day
- 4 x day
- Once every other day
- 1 x week
- 2 x week
- Once every 28 days
- Every 2 Months
- Every 3 Months
- Every 6 Months
- Annually
- PRN
- Unknown
- Other

(26A) Medication Name	(26B) Reason for Prescription <i>See Dictionary #1</i>	(26C) Other Reason for Prescription	(26D) Frequency <i>Select one from above See Dictionary #2</i>	(26E) Date Started	(26F) Date Stopped

ALLERGIES (Repeat 27A – 27C for additional allergies on separate sheet)

(27A) Type	(27B) To What?	(27C) Type of Reaction
<input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Environmental <input type="checkbox"/> Insects <input type="checkbox"/> Other		
<input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Environmental <input type="checkbox"/> Insects <input type="checkbox"/> Other		

Individual's Name: _____

<input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Environmental <input type="checkbox"/> Insects <input type="checkbox"/> Other		
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CURRENT MEDICAL PROBLEMS AND DIAGNOSES

Weight: _____ lbs.
Date: _____

(Select all that apply)

(28) Neurologic:

- Cerebral Palsy Epilepsy / Seizure Disorder Alzheimer's Disease Acquired/Traumatic Brain Injury
- Multiple Sclerosis Amyotrophic lateral sclerosis Huntington's Parkinson's
- Other - If Other, specify: _____

(29) Cardiovascular:

- Coronary Artery Disease Congestive Heart Failure Hypertension Other - If Other, specify: _____

(30) Respiratory:

- Pneumonia Asthma COPD Recurrent Infection Aspiration Other - If Other, specify: _____

(31) Gastrointestinal:

- GERD Dysphagia Constipation PICA Other - If Other, specify: _____

(32) Musculoskeletal:

- Arthritis Osteoporosis Other - If Other, specify: _____

(33) Kidney/Urinary:

- Renal Insufficiency / Failure Urinary Retention Recurrent Infection Other - If Other, specify: _____

(34) Cancer/Neoplasm:

- Lung Cancer Colon Cancer Liver Cancer Brain Cancer
- Prostate Cancer Esophageal Cancer Blood Cancer Other
- Stomach Cancer Pancreatic Cancer Breast Cancer If Other, specify: _____

(35) Metabolic/Endocrine:

- Diabetes Hyperlipidemia Hyperthyroidism Hypothyroidism Other - If Other, specify: _____

(36) Syndromes:

- Autism Spectrum Disorder Cornelia DeLange syndrome Rett Syndrome Velocardiofacial Syndrome (DiGeorge)
- Down Syndrome Fetal Alcohol Syndrome Smith-Magenis syndrome Williams Syndrome
- Prader-Willi Fragile X Tuberous Sclerosis Other
- Angelman syndrome Phenylketonuria (PKU) Turner's Syndrome If Other, specify: _____

(37) Psychiatric:

- Anxiety disorder - Generalized Anxiety Impulse Control Disorder Personality Disorder - Antisocial Sexual disorders
- Anxiety disorder - OCD Mental disorder due to medical problem - related to seizure disorder Personality Disorder - Borderline Substance use disorder
- Anxiety disorder - Panic Disorder/agoraphobia Mental disorder due to medical problem - related to medication side effects Personality Disorder - Paranoid Other
- Anxiety disorder - PTSD Mood disorder - Bipolar disorder Schizophrenia and thought disorders If Other, specify: _____
- Dementia related disorders Mood disorder - Depressive disorder Psychotic Disorder not otherwise specified

(38) General Medical Problems: _____

FUNCTIONAL STATUS (Select all that apply)

(39) Communication:

- Able to Communicate Communication Difficulties/Uses Verbalizations
- Communication Difficulties/Uses Gestures Not Able to Communicate Needs Unable to Use Call Bell
- Only speaks/understands foreign language _____ Unknown

(40) Vision:

- Normal Low Vision Blind Wears Glasses Unknown

(41) Supportive Devices:

- Padded side rails Splints Braces Helmet Other _____ Unknown None

(42) Hearing:

- Normal Hard of Hearing Deaf Hearing Aid Unknown

(43) Toileting Ability:

- Continent Needs Assistance Incontinent Catheterized Other Unknown

(44) Medication Administration:

- Independent/Self Medicates Medication Administered by Staff Unknown

(45) Dining/Eating:

- Independent Needs Assistance Totally Dependent Fed Through a Tube Other Unknown

(46) Diet Texture:

- Regular Chopped Ground Puree Thicken Liquid Unknown

(47) Diet Type (i.e., regular, diabetic, low salt): _____

(48) Ambulation:

- Independent-Steady Independent-Unsteady Needs Assistance-1 person Needs Assistance-2 people or more
- Ambulation Aids - Walker Ambulation Aids - Cane Ambulation Aids - Crutches Ambulation Aids - Wheelchair
- Non-Ambulatory Unknown Other: _____

(48A) If wheelchair: Owns own wheelchair? **(48B)** Date wheelchair acquired: _____

Individual's Name: _____

(49) Personal Hygiene: Independent Special Needs Unknown

(50) Oral Hygiene: Independent Special Needs Unknown

(51) Head of Bed Elevated: Yes No

(52) Any previous problems with anesthesia?: Yes No Unknown

(52A) If yes, explain: _____

SPECIAL NEEDS (Select one)

(53) Usual response to Medical Exams: Cooperates Partially Cooperates Resistant Fearful Unknown

(54) Sedation for clinical visits: Yes No Unknown

(54A) If Yes, what type of clinical visits: _____ (54B) If Yes, type of sedation used: _____

(55) Special positioning required for examination: Yes No Unknown (55A) If Yes, Explain: _____

(56) Double staffing required for assistance with exams: Yes No Unknown (56A) If Yes, Explain: _____

(57) Requires limited waiting periods for exams: Yes No Unknown

(58) Appointment Schedule Preference: Early day End of day Unknown No Preference

(59) Special communication device/method: Yes No Unknown (59A) If Yes, (Explain): _____

(60) Pain Response: Normal Unique Unknown (60A) If Unique, Explain: _____

(61) Signs of Discomfort: Yes No Unknown (61A) If Yes, Explain: _____

CONTACTS - HEALTHCARE PROVIDERS (Repeat 62A – 62H for additional healthcare providers contacts on separate sheet)

(62A) Type/Specialty <i>See Dictionary #3</i>	(62B) Name	(62C) Street Address	(62D) City	(62E) State	(62F) Zip	(62G) Telephone	(62H) Fax

DEMOGRAPHICS

(63) Living Status: Group Home Own Family Independent Home Sharing/Shared Home
(Select one) Other _____

(64) Marital Status (Select one): Single Married Other-Widow Divorced Legally Separated

(65) Work/Day Program Status: (Select all that apply)
 Community Day Support Day Habilitation Regular job Sheltered Retired At home during day Unknown

(66) Nursing Supports available: (Select all that apply)
 In home less than 24 hr In home 24 hr Healthcare Coordination VNA services may be available
 At Day Program No Nursing Supports Unknown

IMMUNIZATIONS / TB TESTING

(67) Date of most recent TETANUS: _____ Administered Unknown Allergic Never

(68) Date of most recent FLU SHOT: _____ Administered Unknown Allergic Never

(69) Date of most recent PNEUMOVAX: _____ Administered Unknown Allergic Never

(70) Dates of HEPATITIS B VACCINE:

(70A) Primary Series (last administered): _____ Series Complete Administered Unknown Allergic Never

(70B) Booster: _____ Administered Unknown Allergic Never

(71) Dates most recent MEASLES/MUMPS/RUBELLA (MMR): _____ Administered Unknown Allergic Never

(72) List any other vaccinations and dates (e.g., Lyme Hepatitis A, Varicella, etc.): _____

Individual's Name: _____

Tuberculosis Skin Test (PPD):

(73) Has the individual ever had a positive skin test for tuberculosis? Yes No Unknown

(73A) If Yes, was any treatment given? Yes No Unknown

(73B) If Yes, please describe. If No, please explain why treatment was not given: _____

(74) Date of last PPD: _____ (74A) If unknown, explain: _____

PAST MEDICAL HISTORY – DDS RELEASE CONTACT

(75) Medical History not released by parent/guardian

For information, contact: (Repeat 75A – 75G for additional contacts on separate sheet)

(75A) Name	(75B) Relationship	(75C) Street Address	(75D) City	(75E) State	(75F) Zip	(75G) Telephone

PAST MEDICAL HISTORY – SURGICAL, TRAUMA AND HOSPITALIZATIONS

(Repeat 76A – 76E for additional events on separate sheet)

(76A) Type of Event (Select one)	(76B) Type of Hospitalization	(76C) Hospital Name	(76D) Description of Event	(76E) Date/Year of Event
<input type="checkbox"/> Broken Bones <input type="checkbox"/> Serious Trauma <input type="checkbox"/> Other	<input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Psychiatric			
<input type="checkbox"/> Broken Bones <input type="checkbox"/> Serious Trauma <input type="checkbox"/> Other	<input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Psychiatric			
<input type="checkbox"/> Broken Bones <input type="checkbox"/> Serious Trauma <input type="checkbox"/> Other	<input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Psychiatric			

PAST MEDICAL HISTORY – GYNECOLOGIC (women only)

(77) Age menstruation started (women only): _____ Unknown

(78) Still menstruating: Yes No (78A) If No, age menstruation stopped: _____ Unknown

(79) Has individual ever given birth to a child? Yes No Unknown

(80) Gynecological exam status: Administered – Date: _____ Never conducted Unknown

(81) PAP Smear Status: Administered – Date: _____ Never conducted Unknown

(82) Any history of abnormal PAP smear? Yes No (82A) If Yes, please describe: _____

(83) Mammogram Status: Administered – Date: _____ Never conducted Unknown

PAST MEDICAL HISTORY – MEDICAL AND PSYCHIATRIC

Past weight: _____ lbs.

Date: _____

(Select all that apply)

(84) Neurologic: Other - If Other, specify: _____

(85) Cardiovascular: Other - If Other, specify: _____

(86) Respiratory: Pneumonia Aspiration Other - If Other, specify: _____

(87) Gastrointestinal: GERD Dysphagia Constipation PICA Other - If Other, specify: _____

(88) Musculoskeletal: Other - If Other, specify: _____

(89) Kidney/Urinary: Renal Insufficiency / Failure Urinary Retention Recurrent Infection Other - If Other, specify: _____

Individual's Name: _____

(90) Cancer/Neoplasm:

- Lung Cancer
- Prostate Cancer
- Stomach Cancer
- Colon Cancer
- Esophageal Cancer
- Pancreatic Cancer
- Liver Cancer
- Blood Cancer
- Breast Cancer
- Brain Cancer
- Other - If Other, specify: _____

(91) Metabolic/Endocrine:

- Diabetes
- Hyperlipidemia
- Hyperthyroidism
- Hypothyroidism
- Other - If Other, specify: _____

(92) Psychiatric:

- Anxiety disorder - Generalized Anxiety
- Anxiety disorder - OCD
- Anxiety disorder - Panic Disorder/agoraphobia
- Anxiety disorder - PTSD
- Dementia related disorders
- Impulse Control Disorder
- Mental disorder due to medical problem - related to seizure disorder
- Mental disorder due to medical problem - related to medication side effects
- Mood disorder - Bipolar disorder
- Mood disorder - Depressive disorder
- Personality Disorder - Antisocial
- Personality Disorder - Borderline
- Personality Disorder - Paranoid
- Schizophrenia and thought disorders
- Psychotic Disorder not otherwise specified
- Sexual disorders
- Substance use disorder
- Other
- If Other, specify: _____

PAST MEDICAL HISTORY – EVALUATIONS

- (93) AUDIOLOGICAL EXAM Status:** Administered – Date: _____ Never Unknown
- (94) EYE EXAM Status:** Administered – Date: _____ Never Unknown
- (95) DENTAL EXAM Status:** Administered – Date: _____ Never Unknown
- (96) PHYSICAL EXAM Status:** Administered – Date: _____ Never Unknown
- (97) BONE DENSITOMETRY (bone thickness) Status:** Administered – Date: _____ Never Unknown
- (98) SIGMOIDOSCOPY or COLONOSCOPY Status:** Administered – Date: _____ Never Unknown
- (99) PSA (prostate cancer screening) Status:** Administered – Date: _____ Never Unknown

FAMILY HISTORY (Part 1)

- (100) FATHER - Is Biological Father Known?** Yes No
- (101) If yes, deceased?** Yes No Unknown
- (101A) If Deceased, age at death:** _____
- (101B) If Deceased, cause of death:** _____
- (101C) If Not Deceased, year of birth:** _____
- (102) MOTHER - Is Biological Mother Known?** Yes No
- (103) If yes, deceased?** Yes No Unknown
- (103A) If Deceased, age at death:** _____
- (103B) If Deceased, cause of death:** _____
- (103C) If Not Deceased, year of birth:** _____
- (104) List all brothers and sisters with information about their age and health:** _____

FAMILY HISTORY (Part 2)

Is there any family history of:

- (105) DIABETES:** Yes No Unknown
- (106) HIGH CHOLESTEROL:** Yes No Unknown
- (107) OSTEOPOROSIS:** Yes No Unknown
- (108) CANCER:** Yes No Unknown
- (108A) If Yes, what Type:** _____
- (109) HIGH BLOOD PRESSURE:** Yes No Unknown
- (110) HEART DISEASE:** Yes No Unknown
- (111) COLON POLYPS:** Yes No Unknown
- (112) Are there any other diseases that “run in the family”?** Yes No Unknown
- (112A) If yes, explain:** _____
- (113) Has there been any genetic counseling in the family?** Yes No Unknown
- (113A) If yes, what were the results?** _____