



My Health Report



Please prepare and share this information with your doctor

About Me

My full name is: _____ I like to be called: _____

I am a person with *(Down syndrome, cerebral palsy, etc.)* _____ Date of Birth: ____ / ____ / ____

Communication Preferences: *(e.g., interpreter, etc.)* _____





I have a legal guardian No Yes, and their name is _____

You can talk to this person about my health: _____ Relationship: _____

The Reason for My Visit Today

Check: Need form Need prescription Annual physical New problem or pain

Describe the problem(s) or pain(s): _____

If pain, it feels like: Burning  Aching  Sharp  Dull  Other

When did it start? _____ Have you had this issue before? _____

What makes it better? *(e.g., rest, medication, etc.)* _____

What makes it worse? *(e.g., eating, activity, etc.)* _____

Since My Last Visit

I have *(list any major medical events, hospitalizations or any other information you feel I should know):*

My overall health is *(better, worse or about the same as my last visit):*

I have generally felt:

  
 happy sad/depressed anxious

Medications I'm Taking

Name	Dose	Freq
<input type="checkbox"/> <i>e.g., Amlodipine</i>	<i>5mg</i>	<i>1x day</i>
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

*If it is new, please check box.
Attach medication list if more space is needed.*

My Medical/Surgical History

I have been diagnosed with *(diabetes, depression, etc.):*

I have been hospitalized for *(bronchitis, an injury, etc.):*

I have had surgery for *(an injury, heart condition, tonsils, etc.):*

My Health Report

My Daily Life

I live:



At home



Group home



Nursing or assisted living facility

I live with (alone, family, friends, other):

I have recently moved: Yes No

My work status:

Employed

Not employed

Student

full time

part time

My job is: _____

Location: _____

I get around by (walking independently, using a power or manual wheel chair, walking with an assistive device, etc.):

Any change in mobility status? Yes No

Please describe _____

Recently, I have been...

Eating more or less

Losing interest in things I liked to do

Feeling tired

Feeling like hurting myself or others

Not able to focus

Having trouble sleeping

Other _____

My Abilities

On My Own With Help

Eat/drink

Use the restroom

Wash/shower/bathe

Get dressed

My Sexual Health

I am sexually active: Yes No

I practice safe sex: Yes No

I need more information about how to practice safe sex: Yes No

I have questions about periods Yes No

I have other questions about sex/sexual concerns Yes No

My Health Maintenance

My last physical: _____

My last eye exam: _____

My last hearing test: _____

My last dental appointment: _____

My last flu shot: _____

My last colonoscopy (if over 50): _____

My last prostate exam & PSA Test (if over 45): _____

My last mammogram/breast exam (if over 40): _____

My last pap smear (if between 21-65): _____

Recent vaccinations (i.e., flu shot): _____

Additional Comments for My Doctor

E.g., Questions about other concerns, about my medication, or activities, etc.

This form was completed by **Print Name** _____

Signature _____ **Date** _____

