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
☐	*e.g., Amlodipine*	*5mg*	*1x day*
☐			
☐			
☐			
☐			
☐			
☐			

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

My job is: _____ ☐ full time ☐ part time

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** _____

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Florida Center for Inclusive Communities FCIC