Medical History Form

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Name: _____ Date: _____
DOB: _____ Social Security Number: _____

Primary care physician: _____ Phone: _____

1. **Specialist**

Specialty:	MD Name:	Phone Number:

2. **Medications**

Medication Name:	Strength / Dose:	Frequency:

3. Medical Condition(s)

4. Surgeries

Surgery type:	Date:

5. Allergies

Type:	Severity:

6. Immunizations

Name:	Date:	Form Received:

7. Sensory

☐ Glasses ☐Contacts ☐Uncorrected vision loss

☐Right ear hearing aid ☐Left ear hearing aid ☐Uncorrected hearing loss

☐Other sensory loss: _____

8. Other Service Provider Names

Name:	Service Provided:	Phone Number:

9. Emergency Contacts

Contact Name:	Relationship:	Phone Number:

10. Check all that apply:

☐ Advance Directive

Representative Name:	Phone Number:

☐ Living Will

Representative Name:	Phone Number:

☐ Durable Power of Attorney for Healthcare (DPOAHC)

Representative Name:	Phone Number:

☐ DNR

Representative Name:	Phone Number:

11. Special Service Devices (i.e. cane, walker, wheelchair, prosthetic limb, brace, spline, pummel cushion, etc.…)

Device name/type:	Order in place (Y or N):	Instructions for use:

12. Insurance Information (helpful, but not required)

Insurance Name:	
Member ID:	
Group Number:	

Insurer's Name:	
Phone Number:	

13. VA Benefit Information (helpful, but not required)

Veteran Name:	
Member ID:	
Phone Number:	

Form Completed by: _____ Date: _____

Relationship to Resident: _____

Signature: _____