

NAME: _____ D.O.B.: _____ DATE: _____

Diagnosis: _____

DD Conditions: MR ____ Date of Onset: _____ Seizures/Epilepsy ____ Date of Onset: _____

CP ____ Date of Onset: _____ Autism ____ Date of Onset: _____

Other: _____ Date of Onset: _____

Food / Drug Allergies: _____

Height: _____ Weight: _____ Pulse: _____ B/P: _____

Restrictions / Limitations for Day Services / Employment: (Be specific- lifting / standing / sitting): _____

Special Dietary Needs / Textures: _____

Eyes	Ears	Nose/Throat
Mouth	Neck	Genitalia
Heart (Murmur Degree)	Lungs	Chest
Extremities	Rectum	Spine
Skin	Abdomen	Reflexes

Current Meds/Dosage/Route/Frequency	Reason	Current Meds/Dosage/Route/Frequency	Reason

**Tetanus Toxoid: Date Given: _____ (Recommended every 10 years by ODH)

**TB Testing: Date Given: _____ Date Read: _____ Negative Positive (Within 6 months of application)

If positive, Chest X-ray given: YES NO Results: _____

I give the nurse permission to administer the following, per recommended label dosage during day program hours:

TYLENOL ASPIRIN ANTACID THROAT LOZENGE IBUPROFEN OTHER _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Printed Name: _____ Telephone: _____

Address: _____ FAX: _____

GENERAL HEALTH HISTORY

Adult Services - Franklin County Board of Mental Retardation and Developmental Disabilities

NAME: _____ D.O.B.: _____ DATE: _____

CARDIOVASCULAR	YES	NO	SKIN	YES	NO	HEMOTOLOGY	YES	NO
Heart Disease			Rashes			Anticoagulant		
High Blood Pressure			Decubitis/Ulcers			Hepatitis		
Low Blood Pressure			Sun Sensitivity			Anemia		
Stroke			Eczema			Bleeding Disorder		

Comments:

Comments:

Comments:

REPRODUCTIVE	YES	NO	RENAL	YES	NO	ENDOCRINE	YES	NO
Irregular Menses			Kidney Disease			Thyroid		
Menopause			Catheter			Diabetes		
Hormone Therapy			Incontinence			Insulin Use		

Comments:

Comments:

Comments:

MUSCU/SKELETAL	YES	NO	RESPIRATORY	YES	NO	SENSORY/NEURO	YES	NO
Arthritis			Asthma			Seizures		
Osteoporosis			COPD			Head Injury		
Amputations			Allergies			Spinal Cord Injury		
Scoliosis			Tuberculosis			Cerebral Palsy		
Frequent Fractures			Frequent Pneumonia			Hydrocephalic		

Comments:

Comments:

Comments:

GASTRO/INTESTINAL	YES	NO	MISC Impairments	YES	NO	HEAT/COLD INTOLERANCE	YES	NO
Constipation			(* explain)			Temperature Limits		
Incontinence			Vision			Heat		
Hemorrhoids			Hearing			Cold		
			Swallowing					
			Speech					

Comments:

Comments:

Comments:

Completed By: _____ Title: _____ Date Completed: _____