HEALTH REVIEW CHECKLIST

To be used by clinical or support staff to record health-related information and to help communicate recent changes to a supervisor or health care provider (HCP). To be completed prior to annual physical and any visit to primary care physician (PCP).

| NAM | ME:DATE:ALLERGI | ES: | | | | | | |
|--|---|------------|----------|---------------|------------------|--|--|--|
| FILLED OUT RV. HCD. | | | | | | | | |
| FILLED OUT BY: Staff Name and Title Health Care Provider | | | | | | | | |
| | Health Status Indicators | | | | | | | |
| ** Highlight or circle changes in health status: | | NO | Yes | Don't Know | Check if | | | |
| | Yes", "Don't know" or "Recent Change" may indicate a need for further ration by the HCP | | | Kilow | recent change | | | |
| | TS: Does this person: | | | | g- | | | |
| 1. | smoke or use tobacco products? | | | | | | | |
| 2. | drink alcohol? | | | | | | | |
| 3. | avoid regular exercise? | | | | | | | |
| 4. | engage in sex? | | | | | | | |
| SLEE | P: Does this person: | | | | | | | |
| 1. | have problems sleeping at night? | | | | | | | |
| 2. | get up 2 or more times during the night to go to the bathroom? | | | | | | | |
| 3. | fall asleep during the day? | | | | | | | |
| | NG/WEIGHT: Has this person: | | | | | | | |
| 1. | gained or lost more than 10 pounds in the past year? | | | | | | | |
| 2. | ever choked while eating? | l <u>U</u> | l ∐ | | | | | |
| 3. | had trouble chewing or swallowing? | | | | | | | |
| 4. | cough or had a change in their breathing during or after eating or drinking? | | | | l ∐ | | | |
| 5. | ever been reluctant to eat or drink? | | | | | | | |
| 6. | needed to change the texture of their food or drink? | | | | | | | |
| | DIAC: Does this person: | | | | | | | |
| 1. | ever complain of chest, jaw, or left arm pain? | | \sqcup | | | | | |
| 2. | have swollen feet or ankles? | | | | | | | |
| 3. | ever have blue lips or nails? | | | | | | | |
| | PIRATORY: Does this person: | | | | | | | |
| 1. | frequently cough or wheeze? | L | l ∐ | | | | | |
| 2. | have shortness of breath when at rest? | | | | | | | |
| 3. | have shortness of breath while exercising? | | | | | | | |
| 4. | have frequent colds, pneumonia, sinus infections or bronchitis? | | | | | | | |
| GASTROINTESTINAL: Does this person: | | | | | | | | |
| 1. | complain of or appear to have heartburn: rub chest, or burp frequently? | | | l ∐ | | | | |
| 2. | vomit 2 or more times per week? | | l ∐ | l ∐ | | | | |
| 3. | complain of or appear to have abdominal pain? | | | | | | | |
| 4. | have a bowel movement less than 3 times per week? | | | | | | | |
| 5. | frequently have 3 or more bowel movements per day? | | | | | | | |
| 6. | seem to have difficulty moving their bowels? | | | | | | | |
| 7. | ever have blood in their bowel movements? | | | | | | | |
| NEUROLOGICAL: Does this person: | | | | | | | | |
| 1. | have a seizure disorder? | ᅵ 닏 | | l H | | | | |
| 2. | complain of headaches, loss of consciousness, or dizziness? | | | l ∐ | | | | |
| 3. | fall a lot or have difficulty with balance? | | | | | | | |
| 4. | walk differently lately? | ∐ | | | | | | |
| 5. | show a change in what their seizures look like? | | | | | | | |
| SKIN & NAILS: Does this person: | | | | | | | | |
| 1. | have dry skin? | l H | | l H | l H | | | |
| 2. | have any rashes, redness or open sores on their skin? | ᅵ 닏 | | l H | l H | | | |
| 3. | have any unusual lumps or bumps on or under the skin? | l ∐ | ▎ ٰ凵 | l ∐ | ▎ ٰЏ | | | |
| 4. | have any unusual marks or moles on the skin or changes in marks/moles? | l ∐ | | | l <u> </u> | | | |
| 5. | have problems with fingernails or toenails? | ∐ | | | | | | |
| 6. | have any blisters or calluses on their feet? | | | | | | | |

| MOUTUTE Does this person: | | Health Status Indicators | NO | YES | Don't Know | Check if recent change |
|--|------|--|------|-----|---------------|------------------------|
| 1. have gums that bleed while brushing their teeth? 2. have any sores in their mouth? 3. grind their teeth? 5. have swollen gums? 1. ever have redness or drainage from their eyes? 1. ever have redness or drainage from their eyes? 2. rob their eyes? 3. squint? 4. ever have drainage from their ears or earwax problems? 5. respond to sound differently lately? 6. ever have drainage from their ears or earwax problems? 7. repond to sound differently lately? 8. ever have trouble using stains? 9. have trouble using stains? 9. have trouble using stains? 1. have trouble using stains; 1. complain of or appear to have joint or muscle pain or stiffiness? 1. complain of or appear to have joint or muscle pain or stiffiness? 2. have any deformities of the feet? 2. have any deformities of the feet? 3. have united that sau nusual color or bad odor? 4. wear special shoes? 6. ENTOURINARY: Does this person: 1. have trouble staring to urinate? 2. complain of pain or burning during or after urinating? 3. have united that sau nusual color or bad odor? 4. have frequent bladder or kidney infections? 5. mentstrate (have a period)? 6. experience pain or other behavior changes during their period (menastrate) (have a period)? 7. report a change in their menstraal cycle? 9. ever bleed or have any unusual discharge from their penis? 10. have any lumps or report pain in their groin? 9. appear musually sad or depressed? 10. have any lumps or report pain in their groin? 10. have any lumps or report pain in their groin? 10. have any lumps or peropt pain in their groin? 11. have trough lumps or report pain in their groin? 12. damage property? 13. appear musually sad or depressed? 14. withdraw from others? 15. display moodiness or irritability 16. eat non-food items? 17. complain of pain? 18. have any contain story of personal losses or major life stressors? 19. display sexually inappropriate behavior? 10. nu or wander away? 11. appear anxious (nervous, agitated, restless)? 12. appear anxious (nervous, agitated, restless)? 13. repeat works and/or a | MOU | TH. Does this person: | | | | |
| 2. have any sores in their mouth? 4. have bud breath? 5. have swollen gums? VISION/HEARING: Does this person: 1. ever have retness or drainage from their eyes? 2. rub their eyes? 3. squint? 4. ever have drainage from their ears or earwax problems? 5. respond to sound differently lately? 6. ewe an bearing aid or glasses? MOBILITY: Does this person: 1. have trouble using statis? 2. have drainage from their ears or earwax problems? 3. have difficulty standing, stiting, or bending? MUSICULOSKELETAL: Does this person: 1. complain of or appear to have joint or muscle pain or stiffiness? 2. have a history of broken bones or osteoporosis (brittle bones)? 3. have unite that has an unusual color or bad oldor? 4. have trouble sturting to urinate? 2. complain of pain or burning during or after urinating? 3. have urine that has an unusual color or bad oldor? 4. have frequent bladder or kidney infections? 5. mentstraute thave a pertodor? 6. experience pain or other behavior changes during their period (menstraute of have protopal) in the statistic or others? 6. ever have any unusual vaginal bleeding or discharge? 9. ever bleed or have unusual discharge from their penis? 9. display earn unusual vaginal bleeding or discharge? 9. ever bleed or have unusual discharge from their penis? 9. display moodiness or irritability 9. display moodiness or irritability 1. hart himself/herself for others? 9. display moodiness or irritability 1. appear anxious (nervous, agitated, restless)? 9. display noodiness or irritability 1. appear anxious (nervous, agitated, restless)? 1. appear anxious (nervous, agitated, restless)? 1. payer or words analy? 1. In poor condition? | | | | | | |
| 3. grind their teeth? 4. have bad breath? 5. have swollen gums? VISION/HEARING: Does this person: 1. ever have redness or drainage from their eyes? 2. rub their eyes? 3. squint? 4. ever have drainage from their ears or earwax problems? 5. respond to sound differently lately? 6. wear a hearing aid or glasses? 6. wear a hearing aid or glasses? 7. have trouble using stairs? 8. have trouble getting around the house? 9. have difficulty standing, sitting, or hending? 11. complain of or appear to have joint or muscle pain or stiffiness? 12. have a history of brokes hones or osteoporosis (brittle bones)? 13. have any deformities of the feet? 14. wear special shose? 15. have trouble starting to urinate? 16. have trouble starting to urinate? 17. have trouble starting to urinate? 18. have urine that has an unusual color or bad odor? 19. have urine that has an unusual color or bad odor? 19. have urine that has an unusual color or bad odor? 19. have urine that has an unusual color or bad odor? 20. have a hange in their menstrual cycle? 21. experience pain or other behavior changes during their period (menstruation)? 22. report a change in their menstrual cycle? 23. ever bleed or have unusual vaginal bleeding or discharge? 24. ever bleed or have unusual discharge from their penis? 25. menstruate (have a period)? 26. experience pain or other behavior changes during their period (menstruation)? 27. report a change in their menstrual cycle? 28. ever have any unusual vaginal bleeding or discharge? 29. ever bleed or have unusual discharge from their penis? 20. have any unpuno or report pain in their groin? 21. hand himself/frestelf or others? 22. damage property? 23. appear anusually sad or depressed? 24. withdraw from others? 25. display moodiness or irritability 26. eat non-food items? 27. complain of pain? 28. have any recent history of personal losses or major life stressors? 29. display sexually inappropriate behavior? 21. In poor condition? 22. Lost? | | | | | | |
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| 2. Lost? | | | | | | |
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| J. Docs not m. | | | | | | |
| 4. Does not work, needs repair? | | | | | | |

Notes:

Adapted from Massachusetts Department of IDD