Life Changes
ELDER CARE CONSULTING LLC

Change Happens. Be Proactive

MEDICAL HISTORY

Name ________________________________ DOB ______________

Height _______ Weight ________ Blood Type _______ Blood Pressure _______ HR________

1. How often does the client visit his/her physician? ____________________________
2. How often does the client visit his/her dentist? ______________________________

In the P/C column mark with a **P** if **past** or if they are an issue for you **currently** mark with a **C**. Please record any other pertinent information in the comments section, and attach any documents, lab results, notes, etc. that are relevant.

P / C	Diagnosis, injury, or Hospitalization	Dates – From – T0
GASTROINTESTINAL		
	Crohn's disease or Ulcerative Colitis	
	Gallstones	
	Irritable Bowel	
	Ulcers	
	Reflux/Heartburn	
	Celiac Disease	
	Constipation	
	Other	
Details (including MD names, procedures, outcomes)		
CARDIAC		
	Heart Attack/Angina	
	Heart Failure	
	Stroke	
	Arrhythmia/irregular heart beat	
	High Cholesterol/triglycerides	
	High Blood Pressure	
	Rheumatic Fever	
	Mitral valve prolapse	
	Other	
Details (including MD names, procedures, outcomes)		

P / C	Diagnosis, injury, or Hospitalization	Dates – From – T0
METOBOLIC/ENDROCRINE		
	Diabetes I or II	
	Low or High Thyroid	
	Metabolic Syndrome, (insulin resistance/ borderline diabetes)	
	Low blood sugars	
	Polycystic ovarian syndrome (PCOS)	
	Infertility	
	Weight Gain	
	Eating Disorder (Bulimia or Anorexia)	
	Other	
Details (including MD names, procedures, outcomes)		
CANCER		
Details (including MD names, procedures, outcomes)		

Life Changes
ELDER CARE CONSULTING LLC

Change Happens. Be Proactive

MEDICAL HISTORY

GENITAL/URINARY TRACK		
	Kidney Stones	
	UTI	
	Yeast Infection	
	Gout	
	Interstitial Cystitis	
	Sexual dysfunction/Erectile dysfunction	
	Other	
Details (including MD names, procedures, outcomes)		

MUSCULOSKETAL/PAIN		
	Osteoarthritis	
	Chronic Pain	
	Other	
Details (including MD names, procedures, outcomes)		

INFLAMATION/AUTOIMMUNE		
	Fibromyalgia	
	Rheumatoid Arthritis	
	Chronic Fatigue Syndrome	
	Lupus SLE	
	Immune Deficiency Disease (HIV)	
	Frequent Infections (describe)	
	Environmental Allergies	
	Food Allergies	
	Chemical Sensitivities	
	Other	
Details (including MD names, procedures, outcomes)		

RESPIRATORY DISEASE		
	Asthma	
	Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	
	Chronic Sinusitis	
	Bronchitis	
	Sleep Apnea	
	Pneumonia	
	Insomnia	
	Other	
Details (including MD names, procedures, outcomes)		

SKIN DISEASE		
	Eczema	
	Psoriasis	
	Acne	
	Skin Cancer (type)	
	Other	
Details (including MD names, procedures, outcomes)		

NEUROLOGICAL/MOOD		
	Depression	
	Anxiety	
	Headaches	
	Bipolar Disorder	
	Schizophrenia	
	ADD/ADHD	
	Autism	
	Headaches (tension or Cluster)	
	Migraine Headaches	
	Memory Problems	
	Parkinson's Disease	
	Multiple Sclerosis	
	Seizure Disorder	
	Other	
Details (including MD names, procedures, outcomes)		

INJURIES		
	Back Injury	
	Broken Bones	
	Head Injury	
	Neck Injury	
	Other (describe)	

Life Changes
ELDER CARE CONSULTING LLC

Change Happens. Be Proactive

MEDICAL HISTORY

Details (including MD names, procedures, outcomes)		
GENDER RELATED		
Details (including MD names, procedures, outcomes)		
ORAL		
Details (including MD names, procedures, outcomes)		
VISION		
Details (including MD names, procedures, outcomes)		

HEARING		
Details (including MD names, procedures, outcomes)		
PLASTIC SURGERY		
Details (including MD names, procedures, outcomes)		
OTHER		
Details (including MD names, procedures, outcomes)		

Allergies

Medications	Reactions
Food	Reactions

Life Changes
ELDER CARE CONSULTING LLC

Change Happens. Be Proactive

MEDICAL HISTORY

Shots/Vaccinations

Dates	Shot/Vaccine
	Flu
	Pneumococcal – PCV 13
	Pneumococcal – PPSV23
	Zostavax (Shingles)
	Shingrix (2017 shingles vaccine)
	Tetanus

Dates	Shot/Vaccine
	Pertussis (whooping cough)
	Tdap (Tetanus, Diphtheria and Pertussis)
	Hepatitis A
	Hepatitis B

Diagnostic Test/Screening

Dates	Test/Screenings	Outcome & Diagnosis
	Bone Density	
	Colonoscopy	
	Cardiac Stress Test	
	EKG	
	CT Scan	
	MRI	

Dates	Test/Screenings	Outcome & Diagnosis
	Ultra Sound	
	Blood work/Labs	
	Pap	
	Mammogram	
	Prostate (PSA, biopsy)	

PROSTHESIS / DENTURES / METAL/JOINT REPLACEMENT

Device & DATES received	Body Part	Notes

ASSISTIVE DIVICES(S)

Device	Using it Properly?	Provider name and phone number	Notes

Life Changes
ELDER CARE CONSULTING LLC

Change Happens. Be Proactive

MEDICAL HISTORY

Smoker? ☐ Yes, currently ☐ Yes, past ☐ Never, If yes, how long? _______, How many packs a day? ______

Other Tobacco Use? ☐ Yes, currently ☐ Yes, past ☐ Never, If yes, how long? _______, What Type?__________

Alcohol use? ☐ Yes, currently ☐ Yes, past ☐ Never, If yes, how much? ______ day, ______ week?

Family History

Medical Illness/Injury	**Family Member (parents, siblings, children (by blood))**
Alcoholism	
Alzheimer's or Dementia	
Asthma/emphysema	
Bleeding disorder	
Cancer, specific type	
Depression/suicide	
Diabetes	
Genetic Disorders	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Rheumatism or Arthritis	
Stoke	
Other	