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).

NAME:_____ **DATE:**_____ **ALLERGIES:**_____

FILLED OUT BY:_____ **HCP:**_____
Staff Name and Title Health Care Provider

Health Status Indicators ** Highlight or circle changes in health status: Any "Yes", "Don't know" or "Recent Change" may indicate a need for further exploration by the HCP	**NO**	**Yes**	**Don't Know**	**Check if recent change**
HABITS: Does this person:				
1. smoke or use tobacco products?	☐	☐	☐	☐
2. drink alcohol?	☐	☐	☐	☐
3. avoid regular exercise?	☐	☐	☐	☐
4. engage in sex?	☐	☐	☐	☐
SLEEP: 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?	☐	☐	☐	☐
EATING/WEIGHT: Has this person:				
1. gained or lost more than 10 pounds in the past year?	☐	☐	☐	☐
2. ever choked while eating?	☐	☐	☐	☐
3. had trouble chewing or swallowing?	☐	☐	☐	☐
4. cough or had a change in their breathing during or after eating or drinking?	☐	☐	☐	☐
5. ever been reluctant to eat or drink?	☐	☐	☐	☐
6. needed to change the texture of their food or drink?	☐	☐	☐	☐
CARDIAC: Does this person:				
1. ever complain of chest, jaw, or left arm pain?	☐	☐	☐	☐
2. have swollen feet or ankles?	☐	☐	☐	☐
3. ever have blue lips or nails?	☐	☐	☐	☐
RESPIRATORY: Does this person:				
1. frequently cough or wheeze?	☐	☐	☐	☐
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?	☐	☐	☐	☐
2. vomit 2 or more times per week?	☐	☐	☐	☐
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?	☐	☐	☐	☐
2. complain of headaches, loss of consciousness, or dizziness?	☐	☐	☐	☐
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?	☐	☐	☐	☐
2. have any rashes, redness or open sores on their skin?	☐	☐	☐	☐
3. have any unusual lumps or bumps on or under the skin?	☐	☐	☐	☐
4. have any unusual marks or moles on the skin or changes in marks/moles?	☐	☐	☐	☐
5. have problems with fingernails or toenails?	☐	☐	☐	☐
6. have any blisters or calluses on their feet?	☐	☐	☐	☐

Health Status Indicators	NO	YES	Don't Know	Check if recent change
MOUTH: Does this person:				
1. have gums that bleed while brushing their teeth?	☐	☐	☐	☐
2. have any sores in their mouth?	☐	☐	☐	☐
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?	☐	☐	☐	☐
MOBILITY: Does this person:				
1. have trouble using stairs?	☐	☐	☐	☐
2. have trouble getting around the house?	☐	☐	☐	☐
3. have difficulty standing, sitting, or bending?	☐	☐	☐	☐
MUSCULOSKELETAL: 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 any deformities of the feet?	☐	☐	☐	☐
4. wear special shoes?	☐	☐	☐	☐
GENITOURINARY: Does this person:				
1. have trouble starting to urinate?	☐	☐	☐	☐
2. complain of pain or burning during or after urinating?	☐	☐	☐	☐
3. have urine that has an unusual color or bad odor?	☐	☐	☐	☐
4. have frequent bladder or kidney infections?	☐	☐	☐	☐
5. menstruate (have a period)?	☐	☐	☐	☐
6. experience pain or other behavior changes during their period (menstruation)?	☐	☐	☐	☐
7. report a change in their menstrual cycle?	☐	☐	☐	☐
8. ever have any unusual vaginal bleeding or discharge?	☐	☐	☐	☐
9. ever bleed or have unusual discharge from their penis?	☐	☐	☐	☐
10. have any lumps or report pain in their groin?	☐	☐	☐	☐
BEHAVIOR: Currently, does this person ever:				
1. hurt himself/herself or others?	☐	☐	☐	☐
2. damage property?	☐	☐	☐	☐
3. appear unusually sad or depressed?	☐	☐	☐	☐
4. withdraw from others?	☐	☐	☐	☐
5. display moodiness or irritability	☐	☐	☐	☐
6. eat non-food items ?	☐	☐	☐	☐
7. complain of pain?	☐	☐	☐	☐
8. have any recent history of personal losses or major life stressors?	☐	☐	☐	☐
9. display sexually inappropriate behavior?	☐	☐	☐	☐
10. run or wander away?	☐	☐	☐	☐
11. appear anxious (nervous, agitated, restless)?	☐	☐	☐	☐
12. appear forgetful?	☐	☐	☐	☐
13. repeat words and/or actions again and again?	☐	☐	☐	☐
ADAPTIVE EQUIPMENT: Is adaptive equipment:				
1. In poor condition?	☐	☐	☐	☐
2. Lost?	☐	☐	☐	☐
3. Does not fit?	☐	☐	☐	☐
4. Does not work, needs repair?	☐	☐	☐	☐

Notes:

Adapted from Massachusetts Department of IDD