MONTHLY HEALTH REVIEW

NAME: ______________________________ REVIEW MONTH: _________________________

		ISSUES ?		COMMENTS
		Yes	No	
1	Skin			
2	Skeletal			
3	Neurological			
4	Cardiac			
5	Respiratory			
6	Head/Neck			
7	Gastrointestinal			
8	Urinary			
9	Reproductive			
10	Other			
11	Med Changes			
12	PRN Meds Used (Note Results)			
13	Side Effects of Meds			
14	Illnesses/Injuries			
15	Seizures			
16	Diet			
17	Weight/DWR			
18	Dietary Concerns			
19	Vaccinations			
20	Lab Reports			

21	**Medical Appointments Therapy Evals & Follow-up (Note Outcome)**			
22	**Behavioral Concerns / Psych Med Review**			
23	**Swallowing/Dysphagia Concerns**			
24	**Other Significant Health Concerns**			

25	**Consultations** (Include date, time, whether direct observation or staff report and signature with each entry.)
	Week 1 date:
	Week 2 date:
	Week 3 date:
	Week 4 date:
	Name: **Month/Year:**