Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

SUMMARY LIST

Significant Medical Diagnoses and Conditions	**Check One**		**Currently Under a Doctor's Care**	**Comment**
	Now	**Past**		
Alzheimer's Disease or Dementia	☐	☐		
Blood Sugar-High	☐	☐		
Blood Pressure (High)	☐	☐		
Cancer	☐	☐		
Deafness or other hearing impairment	☐	☐		
Diabetes	☐	☐		
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	☐	☐		
Epilepsy/Seizures	☐	☐		
Heart Attack	☐	☐		
Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides)	☐	☐		
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis	☐	☐		
Kidney Disease	☐	☐		
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	☐	☐		
Mobility Impairment	☐	☐		
Other Cardiac Condition	☐	☐		
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	☐	☐		
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	☐	☐		
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	☐	☐		

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Sight Impairment	☐	☐		
Speech Impairment	☐	☐		
Stroke	☐	☐		
Traumatic Brain Injury	☐	☐		
Weight (Obesity, Unexplained Gain or Loss)	☐	☐		
Other physical related health conditions	☐	☐		
Other:	☐	☐		
Other:	☐	☐		
Other:	☐	☐		
Other:	☐	☐		
Other:	☐	☐		

Medical hospitalizations/significant operative and invasive procedures?

☐ No ☐ Yes If yes, complete information below.

Hospital	Date	Reason

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Medication List

List all medications individual in care is taking including medications prescribed by this provider, medications prescribed by outside prescribers as well as herbal remedies, vitamins, nutraceuticals, or over-the-counter drugs.

Date	Medication	Dosage / Route / Frequency	Supply: Amount / Refills	Status	Purpose	Rationale for Change	Name of Prescriber	Source of Knowledge
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report
				☐ New/Adj. ☐ Continue ☐ Discont.				☐ Prescriber ☐ Outside Prescriber ☐ Pharmacy ☐ Individual Self-Report

ALERTS- Medication Allergy/Adverse Events: