

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). Must 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 <i>** Highlight or circle any changes in health status. Any "Yes", "Don't Know" or "Recent Change" may indicate a need for further exploration by the HCP.</i>	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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

¹ Adapted from the Massachusetts Department of MR

10. run or wander away?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. appear anxious (nervous, agitated, restless)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. appear forgetful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. repeat words and/or actions again and again?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>