



## **HEALTH REVIEW CHECKLIST**

### **OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES**

**PURPOSE:** To maintain health history and to provide information to new staff or any physician providing health care.

**COMPLETED BY:** The individual or staff working with the individual.

#### **WHY THIS IS IMPORTANT:**

- If done on a regular basis, could alert the individual, staff and/or physician to changes in health status.
- Would prompt quicker action of treatments – i.e., change medication dosages relating to change in condition.

**(See Form Next Page)**

# HEALTH REVIEW CHECKLIST<sup>1</sup>

## Ohio Department of Developmental Disabilities

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*

<b>Health Status Indicators</b>	<b>No</b>	<b>Yes</b>	<b>Don't Know</b>	<b>Check if recent change</b>
<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>				
<b>HABITS</b> Does this person:				
1. Smoke or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Avoid regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Engage in sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SLEEP</b> Does this person:				
1. Have problems sleeping at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Get up 2 or more times during the night to go to the bathroom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fall asleep during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EATING/WEIGHT</b> Has this person:				
1. Gained or lost more than 10 pounds in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever choked while eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Had trouble chewing or swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Coughed or had a change in their breathing during or after eating or drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever been reluctant to eat or drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Needed to change the texture of their food or drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CARDIAC</b> Does this person:				
1. Ever complain of chest, jaw or left arm pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have swollen feet or ankles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever have blue lips or nails?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b> Does this person:				
1. Frequently cough or wheeze?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have shortness of breath when at rest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have shortness of breath while exercising?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have frequent colds, pneumonia, sinus infections or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GASTROINTESTINAL</b> Does this person:				
1. Complain of or appear to have heartburn; rub chest or burp frequently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Vomit 2 or more times per week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Complain of or appear to have abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have a bowel movement less than 3 times per week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Frequently have 3 or more bowel movements per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Seem to have difficulty moving their bowels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever have blood in their bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b> Does this person:				
1. Have a seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Complain of headaches, loss of consciousness or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fall a lot or have difficulty with balance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Walk differently lately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Show a change in what their seizures look like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>1</sup>Adapted from the Massachusetts Department of Developmental Services.

# HEALTH REVIEW CHECKLIST<sup>1</sup>

## Ohio Department of Developmental Disabilities

<b>Health Status Indicators</b> <small>**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.</small>	<b>No</b>	<b>Yes</b>	<b>Don't Know</b>	<b>Check if recent change</b>
<b>SKIN &amp; NAILS</b> 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? 5. Have problems with fingernails or toenails? 6. Have any blisters or calluses on their feet?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>MOUTH</b> 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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>VISION/HEARING</b> 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 sounds differently lately? 6. Wear a hearing aid or glasses?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>MOBILITY</b> Does this person: 1. Have trouble using stairs? 2. Have trouble getting around the house? 3. Have difficulty standing, sitting or bending?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>MUSCULOSKELETAL</b> Does this person: 1. Complain of or appear to have joint or muscle pain or stiffness? 2. Have a history of broken bones or osteoporosis (brittle bones)? 3. Have any deformities of the feet? 4. Wear special shoes?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>GENITOURINARY</b> 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?	<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"/> <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"/>
<b>BEHAVIOR</b> Currently, does this person: 1. Hurt himself/herself or hurt 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/major life stressors? 9. Display sexually inappropriate behavior? 10. Run or wander away? 11. Appear anxious (nervous, agitated, restlessness)? 12. Appear forgetful? 13. Repeat words and/or actions again and again?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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