Medical History Summary:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Name:

How Related:

Mobile:

Landline:

2nd Next of Kin Name:

How Related:

Mobile:

Landline:

|  |  |
| --- | --- |
| Communication(circle answer) | Preferred language: English / Gujarati / bothCan speak English – none / some / well / fluentCan understand English – none / some / well / fluentVision – vision ok without glasses / wears glassesHearing – hearing ok / hard of hearing / wears hearing aids |
| Personal Care(circle answer) | Dental – own teeth / denturesSwallowing – no problems / adjusted diet (write details)Toileting – can use toilet / uses pads / wears nappyWashing – can wash and dress / needs assistance / needs total helpSkin – skin intact / damaged skin / pressure sore |
| Drug or medication allergies | No known drug allergies / Drug Allergy (list below with details) |
| Food allergy and diet (circle answer) | Vegan / Vegetarian (no eggs) / Vegetarian (eats eggs) / Other:No food allergy / Food allergy (list below with details)  |
| Smoking/Alcohol | Smoking – never smoked / previously smoked / current smokerAlcohol – no alcohol / infrequent alcohol / regular alcoholAny herbal or ayurvedic tablets: No / Yes (list below)  |
| How do they walk | By themselves / with a stick / with a zimmer frame / uses wheelchair / hoist / stays in bed |
| Medical Problems (circle yes or no) | High blood pressure Yes/NoDiabetes Yes/NoKidney disease Yes/NoDepression/Anxiety Yes/No | High cholesterol Yes/NoAsthma/COPD Yes/NoThyroid disease Yes/NoAnaemia Yes/No |
| Please write any details alongside:Stroke Yes/No Heart attack Yes/No Heart bypass or angiogram Yes/No Heart failure (with fluid in legs or lungs) Yes/No Cancer Yes/No Eye problems Yes/No Memory problems or confusion Yes/No  |
| Any other medical problems |  |
| Previous Surgery |  |
| Medication ListWhat medicationWhat doseWhen taken |  |