My Health Report

Please prepare and share this information with your doctor

About Me

My full name is: ______________________ I like to be called: ______________________

I am a person with *(Down syndrome, cerebral palsy, etc.)* ______________________ Date of Birth: ____/____/____

Communication Preferences: *(e.g., interpreter, etc.)* ______________________

I have a legal guardian ☐ No ☐ Yes, and their name is ______________________

You can talk to this person about my health: ______________________ Relationship: ______________________

The Reason for My Visit Today

Check: ☐ Need form ☐ Need prescription ☐ Annual physical ☐ New problem or pain

Describe the problem(s) or pain(s): ______________________

If pain, it feels like: ☐ Burning ☐ Aching ☐ Sharp ☐ Dull ☐ Other

When did it start? ______________________ Have you had this issue before? ______________________

What makes it better? *(e.g., rest, medication, etc.)* ______________________

What makes it worse? *(e.g., eating, activity, etc.)* ______________________

Since My Last Visit

I have *(list any major medical events, hospitalizations or any other information you feel I should know)*:

____

____

____

My overall health is *(better, worse or about the same as my last visit)*:

____

I have generally felt:

☐ happy ☐ sad/depressed ☐ anxious

Medications I'm Taking

	Name	Dose	Freq
☐	e.g., Amlodipine	5mg	1x day
☐			
☐			
☐			
☐			
☐			
☐			

If it is new, please check box.
Attach medication list if more space is needed.

My Medical/Surgical History

I have been diagnosed with *(diabetes, depression, etc.)*:

____

____

____

I have been hospitalized for *(bronchitis, an injury, etc.)*:

____

I have had surgery for *(an injury, heart condition, tonsils, etc.)*:

____

My Health Report

My Daily Life

I live:

☐ At home ☐ Group home ☐ Nursing or assisted living facility

I live with *(alone, family, friends, other)*: ______________________

I have recently moved: ☐ Yes ☐ No

My work status:

☐ Employed ☐ Not employed ☐ Student ☐ full time ☐ part time

My job is: ______________________

Location: ______________________

I get around by *(walking independently, using a power or manual wheel chair, walking with an assistive device, etc.)*: ______________________

Any change in mobility status? ☐ Yes ☐ No

Please describe ______________________

Recently, I have been…

☐ Eating more or less

☐ Losing interest in things I liked to do

☐ Feeling tired

☐ Feeling like hurting myself or others

☐ Not able to focus

☐ Having trouble sleeping

☐ Other ______________________

My Abilities

	On My Own	With Help
Eat/drink	☐	☐
Use the restroom	☐	☐
Wash/shower/bathe	☐	☐
Get dressed	☐	☐

My Sexual Health

I am sexually active:	☐ Yes	☐ No
I practice safe sex:	☐ Yes	☐ No
I need more information about how to practice safe sex:	☐ Yes	☐ No
I have questions about periods	☐ Yes	☐ No
I have other questions about sex/sexual concerns	☐ Yes	☐ No

My Health Maintenance

My last physical: ______________________

My last eye exam: ______________________

My last hearing test: ______________________

My last dental appointment: ______________________

My last flu shot: ______________________

My last colonoscopy *(if over 50)*: ______________________

My last prostate exam & PSA Test *(if over 45)*: ______________________

My last mammogram/breast exam *(if over 40)*: ______________________

My last pap smear *(if between 21-65)*: ______________________

Recent vaccinations *(i.e., flu shot)*: ______________________

____

Additional Comments for My Doctor

E.g., Questions about other concerns, about my medication, or activities, etc.

____

____

This form was completed by *Print Name* ______________________

Signature ______________________ **Date** ______________________

Please cite this document as:
Perkins, E.A., & VanZant, S. (2015). *My Health Report.* Florida Center for Inclusive Communities.
For more information visit www.flcic.org.