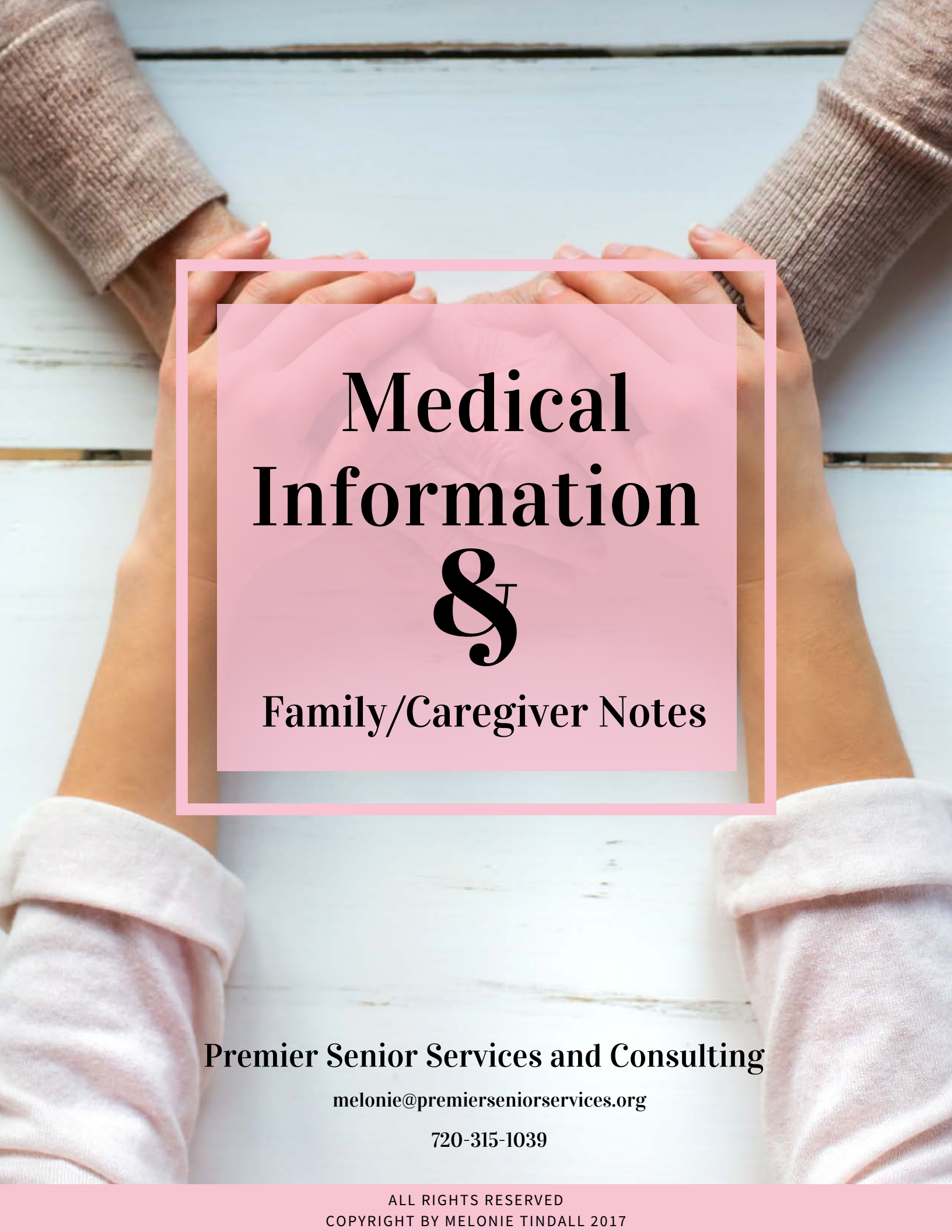

Medical Information &

Family/Caregiver Notes

Premier Senior Services and Consulting

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720-315-1039

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This ebook is an easy approach to keeping your medical paperwork together and accessible at a moment's notice. It is set up in an easy to understand way and has a place for important information as well as the ability to add specific documents to it. After printing it out, consider placing in in a binder with copies of powers of attorney, advanced directives and other pertinent medical paperwork. This will provide both you and your loved one an easy tool to take to physician appointments or other medical encounters. We also offer a hard copy binder with all of your state specific documents included if you do not have them yet. Because you have purchased this eBook, we deeply discount it for you.

The author has worked in the geriatric industry for the past 35 years. Over the years one of the biggest concerns among healthcare professionals is not being able to access all healthcare information in one central document. This eBook removes that problem.

Please feel free to reach out to us with any questions. We can most easily be reached either by email or through a call. You can also visit our website at PremierSeniorServices.Org. Email us at **melonie@PremierSeniorServices.org** or call **720-315-1039.** We look forward to hearing from you.

EMERGENCY CONTACT INFORMATION

FIRST CONTACT

NAME .....
CELL PHONE .....
WORK .....
HOME .....
ADDRESS .....
RELATIONSHIP TO ME .....

SECOND CONTACT

NAME .....
CELL PHONE .....
WORK .....
HOME .....
ADDRESS .....
RELATIONSHIP TO ME .....

HOSPITAL OF PREFERENCE .....
ADDRESS .....
PHYSICIAN TO BE NOTIFIED .....
PHONE NUMBER/ADDRESS .....

MY HEALTH HISTORY

NAME ..... BIRTHDATE .....

GENDER ☐ MALE ☐ FEMALE HEIGHT ..... WEIGHT .....

PRIMARY PHYSICIAN ..... PHONE NUMBER .....

ADDRESS .....

LIST OF OTHER PHYSICIANS/NEDICAL PROFESSIONALS

NAME ..... PHONE NUMBER .....

WHAT I SEE THIS PHYSICIAL/MEDICAL PROFESSIONAL FOR .....

NAME ..... PHONE NUMBER .....

WHAT I SEE THIS PHYSICIAL/MEDICAL PROFESSIONAL FOR .....

NAME ..... PHONE NUMBER .....

WHAT I SEE THIS PHYSICIAL/MEDICAL PROFESSIONAL FOR .....

NAME ..... PHONE NUMBER .....

WHAT I SEE THIS PHYSICIAL/MEDICAL PROFESSIONAL FOR .....

NAME ..... PHONE NUMBER .....

WHAT I SEE THIS PHYSICIAL/MEDICAL PROFESSIONAL FOR .....

CURRENT DIAGNOSIS AND OTHER MEDICAL CONDITIONS:

PROSTHETICS (INCLUDING DENTURES)

ALLERGIES - MEDICATION, FOOD, OTHER (INDICATE REACTION TO EACH ALLERGY IF KNOWN)

HEALTH HABITS

SMOKING ☐ YES ☐ NO FREQUENCY .....

ALCOHOL ☐ YES ☐ NO FREQUENCY .....

EXERCISE ☐ YES ☐ NO FREQUENCY .....

PAST MEDICAL HISTORY - PLEASE INDICATE YES OR NO TO EACH OF THE FOLLOWING QUESTIONS, FOR EACH YES PLEASE PROVIDE ANY PERTINENT INFORMATION.

☐ YES ☐ NO Heart condition .....

☐ YES ☐ NO Heart attack (date treatment) .....

☐ YES ☐ NO Hypertension .....

☐ YES ☐ NO Stroke/CVA (date treatment) .....

☐ YES ☐ NO Chronic pulmonary disease .....

☐ YES ☐ NO Angina .....

☐ YES ☐ NO High cholesterol .....

☐ YES ☐ NO Diabetes .....

☐ YES ☐ NO Dizziness or fainting .....

☐ YES ☐ NO Arthritis .....

☐ YES ☐ NO Osteoporis .....

☐ YES ☐ NO Hx of falls .....

☐ YES ☐ NO Metabolic Disorder .....

☐ YES ☐ NO Orthopedic concerns (joint replacements/hip fix etc) .....

.....

☐ YES ☐ NO History of Cancer (specify) .....

☐ YES ☐ NO History of Mental illness (specify) .....

☐ YES ☐ NO Memory or Cognitive issues (specify) .....

YES NO Recent weight changes .....

YES NO Surgery in the past year (specify) .....

YES NO Other significant surgeries .....

YES NO Other diagnosis or conditions not listed elsewhere .....

Date of last flu shot .....

Date of last Pneumovax shot .....

Any other pertinent information

MY PRESCRIPTIONS

DATE THIS PAGE UPDATED

.....

	MEDICATION	DOSAGE	DIRECTIONS
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

	SUPPLEMENTS	DOSAGE	DIRECTIONS
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

INFORMATION I WOULD LIKE MY CAREGIVER TO KNOW

I LIVED ON MY OWN UNTIL .....

WHY I CHOSE NOT TO LIVE ON MY OWN .....

THE FIRST ISSUES I NOTICED WERE .....

LANGUAGES I SPEAK ARE .....

THE THINGS THAT I NEED HELP WITH ARE:

- [ ] Driving
- [ ] Cooking
- [ ] Medication reminders
- [ ] General homemaking
- [ ] Laundry
- [ ] Appointment management
- [ ] Shopping
- [ ] Dressing
- [ ] Hair care
- [ ] Makeup application
- [ ] Bathing
- [ ] Toileting
- [ ] Oral Care
- [ ] Other

I LIKE TO BE DRESSED EACH DAY IN .....

I LIKE TO HAVE MY HAIR DONE DAILY .....

I LIKE TO HAVE MY MAKEUP APPLIED DAILY .....

I WEAR GLASSES .....

I WEAR DENTURES/PARTIALS .....

MEMORY IMPAIRMENT / DEMENTIA INFORMATION

DIAGNOSIS AND DATE THE DIAGNOSIS WAS GIVEN .....

.....

PHYSICIAN WHO PROVIDED DIAGNOSIS AND TESTING

NAME ..... PHONE NUMBER .....

1. HISTORY OF BEHAVIORS / SYMPTOMS

Y ☐ N ☐ HABITUAL WANDERING .....

Y ☐ N ☐ DISRUPTIVE BEHAVIORS .....

Y ☐ N ☐ COMBATIVE BEHAVIORS .....

2. UNUSUAL BEHAVIORS .....

3. IDIOSYNCRASIES .....

4. WHAT I REACT BEST TO .....

5. THINGS THAT SET ME OFF .....

6. THINGS THAT CALM ME .....

7. FAVORITE FOOD/BEVERAGE .....

8. OTHER IMPORTANT INFORMATION .....

.....

.....

.....

.....

CAREGIVER DUTIES

DATE:_____

ARRIVAL TIME:_____

DEPARTURE TIME:_____

ACTIVITIES TO DO WITH CLIENT

1. _____ ☐
2. _____ ☐
3. _____ ☐
4. _____ ☐
5. _____ ☐

ACTIVITIES TO DO WITH CLIENT

1. _____ ☐
2. _____ ☐
3. _____ ☐
4. _____ ☐
5. _____ ☐

COMMUNICATION LOG

SOME OF MY FAVORITE THINGS

- [ ] I prefer to dress casually daily
- [ ] I prefer to be dressed up daily
- [ ] I enjoy wearing jewelry each day
- [ ] I typically am cold and like to have a sweater
- [ ] I wear glasses at all times
- [ ] I wear glasses only to read
- [ ] I enjoy wearing hats
- [ ] I enjoy wearing scarves
- [ ] I wear makeup everyday
- [ ] I wear perfume/aftershave daily

I GO TO THE HAIR SALON ON .....

MY HAIRDRESSER IS .....

PHONE NUMBER .....

BATHING PREFERENCE ☐ SHOWER ☐ BATH

HELPFUL HINTS FOR BATHING .....

TIME OF DAY I PREFER TO BATH .....

DAYS OF THE WEEK I PREFER TO BATH ON .....

MY TOILETING NEEDS ARE:

- [ ] I am independent in my toileting
- [ ] I need assistance finding the bathroom/toilet
- [ ] I need assistance toileting
- [ ] I need help with clothing management
- [ ] I need reminders to sit down on the toilet
- [ ] I need help cleaning myself
- [ ] I need help flushing the toilet
- [ ] I need help washing my hands
- [ ] I am incontinent and wear briefs
- [ ] I exhibit behaviors when I need to be toileted

MY ORAL CARE NEEDS ARE:

- [ ] I brush my own teeth/dentures/partials
- [ ] I need assistance with set up of toothbrush and toothpaste
- [ ] I need assistance brushing my teeth/dentures/partials
- [ ] I use mouthwash following brushing of my teeth

MY GAIT AND BALANCE NEEDS ARE:

- [ ] I walk independently
- [ ] I need handheld assistance when I walk
- [ ] I need assistance getting in and out of bed
- [ ] I use an assistive device

Device .....

- [ ] I have a history of frequent falls

Number of falls in the past 3 months .....

MY EATING HABITS ARE:

- [ ] I eat independently
- [ ] I am able to use utensils
- [ ] I eat finger foods
- [ ] I need reminders during eating a meal
- [ ] I need encouragement to eat
- [ ] I have foods I enjoy and eat best .....
- [ ] I have beverages of preference .....
- [ ] I drink coffee with my meal -or- [ ] drink coffee following my meal
- [ ] I have foods I do not enjoy/avoid

.....

- [ ] I have favorite snacks .....
- [ ] I have specific meal preferences and times

Breakfast .....

Lunch/Dinner .....

Supper .....

SOME OTHER THING I WANT YOU TO KNOW ABOUT ME:

MY NORMAL DISPOSITION IS .....

WHEN I AM UPSET THE THING THAT CALMS ME DOWN IS .....

THE KIND OF MUSIC I ENJOY IS .....

THE KIND OF ACTIVITIES I ENJOY ARE .....

I HAVE MY OWN CELL PHONE AND USE IT DAILY .....

☐ I ENJOY BEING ALONE -OR- ☐ I ENJOY BEING A PART OF A GROUP

MY NORMAL PERSONALITY IS ☐ QUIET -OR- ☐ OUTGOING

SOME OTHER THINGS I ENJOY ARE

- ☐ walks
- ☐ shopping
- ☐ helping around the house
- ☐ gardening
- ☐ being outdoors
- ☐ watching television
- ☐ napping

ADDITIONAL INFORMATION I WOULD LIKE YOU TO KNOW ABOUT ME

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY