

**Taking Charge: Good Medical Care for the Elderly
and How to Get It**

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APPENDIX H

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Appendix H Medical History

The following questions are relevant to establishing a baseline for your loved one's health. Complete this chart and use it in your three-ring binder as your own medical record. Update it periodically, at least once a month and preferably once a week, or whenever you observe a change in the physical or mental status of your loved one. Remember, your loved one should be weighed once a week at the same time of day, on the same scale, wearing the same or similar clothing.

Today's Date _____

Name _____

Birthdate _____ Age _____

Height _____ Weight _____

Body weight _____ one month ago _____ six months ago _____

Has this patient lost five lbs. or 5% in one month? _____

Has this patient lost 10 lbs. or 10% in the past six months? _____

Body Mass Index (Trigger: Greater than 27? Less than 22?) _____

Vital signs (Normal for this individual) _____

Respiration _____ Blood pressure _____

Temperature _____ Pulse _____

Immunization history (Date of last shot)

Tetanus _____ Pneumococcal vaccine _____

Influenza vaccine _____

Recent illness(es); hospitalization(s) *Attach discharge summary(ies)*

Dates *Diagnosis/Illness/Hospitalization (reason for)*

Appendices

Date of last _____

Blood transfusion _____

Anesthesia _____

Complications of illness/operation(s) in past year _____

Screening tests in past year [Insert dates]

structural colon studies _____ lipid levels _____

electrocardiograms and stress tests _____

mammograms _____ Pap smears _____

prostate examination _____

prostate-specific antigen levels _____

ordinary laboratory tests (creatinine, glucose, hemoglobin) _____

Who has records of these tests? [Attach if possible] _____

Eating habits: It will be helpful if you keep a checklist recording your loved one's eating habits in the three-ring binder that you are assembling. When you note changes in these habits, you may want to re-evaluate for protein/energy malnutrition.

(Check all that apply)

- Does not have enough food to eat each day
- Usually eats alone
- Does not eat anything on one or more days each month
- Has poor appetite
- Is on a special diet

Appendices

(Eating habits continued)

- Eats vegetables two or fewer times daily
- Consumes milk or milk products once or not at all daily
- Consumes fruit or fruit juice once or not at all daily
- Eats breads, cereals, pasta, rice, or other grains five or fewer times daily
- Has difficulty chewing or swallowing
- Has more than one alcoholic drink per day (if female); more than two drinks per day (if male)
- Has pain in mouth, teeth, or gums
- Uses tobacco
- Drinks coffee/other caffeinated drinks

Chronic diseases or conditions

Name of disease/condition Date diagnosed Physician Medication(s)

Current medications, including prescription and nonprescription drugs, health aids, and over-the-counter products, including vitamin supplements

NAME	DOSAGE	SCHEDULE	DURATION	PRESCRIBER
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Appendices

Has this individual experienced any of the following in the past year?

- Sodium and potassium depletion associated with diuretic use
- Extrapyramidal symptoms resulting from use of psychotropic medication(s)
- Gastrointestinal bleeding caused by aspirin or other NSAIDs
- Falls associated with medication use
- Hemorrhagic reactions from heparin and warfarin

Does this individual experience any of the following?

Condition

How Long?

- Gastrointestinal bleeding caused by aspirin or other NSAIDs _____
- Dependence in activities of daily living (esp. eating and dressing) _____
- Bladder or bowel incontinence _____
- Dementia or delirium _____

Does this individual experience any of the following?

Condition

How Long?

- Need for home health services _____
- New or complex drug regimens _____
- Need for rehabilitative services _____
- Intravenous therapy or nutritional support _____
- Wounds or pressure sores _____
- Care of ventilators, stomas, tubes, or appliances _____

Current symptoms _____

Hearing/vision: Describe any difficulties _____

Mental status

- Alert
- Talks logically
- Awake appropriately
- Demonstrates logical thinking
- Memory intact Short term _____ Long term _____

Appendices

Leisure activities: Likes to do the following:

- Read
- Watch TV
- Travel
- Take walks
- Socialize

Any emotional difficulties? Yes _____ No _____

Describe: _____

Any significant stressors

- Move to different housing
- Lost spouse
- Lost job
- Moved to nursing home
- Recent stroke
- Recent surgery

Appendices

FAMILY MEDICAL HISTORY

Patient's spouse

Name _____ Age _____

Age and date of death _____ Cause of death _____

Patient's parents

Mother's name _____ Age _____

Age and date of death _____ Cause of death _____

Father's name _____ Age _____

Age and date of death _____ Cause of death _____

Sibling's name _____ Age _____

Age and date of death _____ Cause of death _____

Sibling's name _____ Age _____

Age and date of death _____ Cause of death _____

Sibling's name _____ Age _____

Age and date of death _____ Cause of death _____

Sibling's name _____ Age _____

Age and date of death _____ Cause of death _____

Is there any history of dementia in this individual's family?

No _____ Yes _____

If yes, please give details: _____

Symptoms

Does this individual have any symptoms related to the following?

— Heart disease

— Cancer

— Stroke

— Infection

Appendices

Does this individual have any symptoms related to the following?

- Diabetes mellitus
- Vision and hearing problems
- Constipation
- Sleep difficulties
- Problems with the feet
- Incontinence
- Dizziness
- Falls
- Mouth problems
- Denture problems
- Swallowing difficulties
- Arthritis
- Sexual problems
- Memory loss
- Depression

Does this individual experience any of the following?

- Sadness
- Crying spells
- Anxiety
- Hyperactivity
- Hostility

Does this individual experience any of the following?

- Decreased interest in social participation
- Poor concentration
- Pessimism about the future
- Thinking about past