

## My Health Report



Please prepare and share this information with your doctor

	About Me							
My full name is:			_ I like to be call	I like to be called:				
l am a person with (Down syndrome, cerebral palsy, etc.)				Date of Birth:	/ /			
Communication Preference	es: (e.g., interpreter,	etc.)						
I have a legal guardian □	No ☐ Yes, and	their name is	S					
You can talk to this person about my health:				Relationship:				
The Reason for My Visit Today								
Check: ☐ Need form	☐ Need prescription		☐ Annual phys	ical 🔲 New prob	☐ New problem or pain			
Describe the problem(s) or pain(s):								
If pain, it feels like:	☐ Burning 👋	<b>□</b> Achi	ng <b>≋</b> □ Sha	arp 🗲 🔲 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:							
			-		60			
			- □ hanny	□ cad/depressed	□ apvious			
			☐ happy	☐ sad/depressed	□ anxious			
Medications I'm Taking My Medical/Surgical History								
Name	Dose	Freq	I have been o	diagnosed with (diabetes, depi	ression, etc.) <b>:</b>			
□ e.g., Amlodipine	5mg	1x day						
			I have been I	I have been hospitalized for (bronchitis, an injury, etc.):				
			I have had su	urgery for (an injury, heart condi	tion, tonsils, etc.):			
If it is new nla	ease check box.							

Attach medication list if more space is needed.

## **My Health Report**

My Daily Life	My Abilities						
Hive:	On My Ov	vn With Help					
	Eat/drink						
ĬŶŶŶ V	Use the restroom						
	Wash/shower/bathe □						
At home Group home Nursing or assisted living facility	Get dressed						
I live with (alone, family, friends, other):	My Sexual Health						
I have recently moved: ☐ Yes ☐ No	I am sexually active:	☐ Yes ☐ No					
My work status:	I practice safe sex:	☐ Yes ☐ No					
☐ Employed ☐ Not employed ☐ Student	I need more information about						
My job is: part time	how to practice safe sex:	☐ Yes ☐ No					
Location:	I have questions about periods	☐ Yes ☐ No					
l get around by (walking independently, using a power or manual wheel chair, walking with an assistive device, etc.):	I have other questions about sex/sexual concerns	☐ Yes ☐ No					
Any change in mobility status?	My Health Main:  My last physical:						
Recently, I have been	My last eye exam:						
☐ Eating more or less	My last hearing test: My last dental appointment:						
☐ Losing interest in things I liked to do	My last flu shot:						
☐ Feeling tired	My last colonoscopy (if over 50):						
☐ Feeling like hurting myself or others	My last prostate exam & PSA Test (if over 45):						
☐ Not able to focus	My last mammogram/breast exam (if over 40):						
	My last pap smear (if between 21-65):  Recent vaccinations (i.e., flu shot):						
☐ Having trouble sleeping	Recent vaccinations (i.e., flu shot):						
Other							
Additional Comments for My Doctor							
E.g., Questions about other concerns, about my medication, or activities, etc.							
This form was completed by Print Name							
This form was completed by Plint Name							



## Please cite this document as:

Perkins, E.A., & VanZant, S. (2015). *My Health Report*. Florida Center for Inclusive Communities.

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