



Forest Green

SUPPLEMENTAL MEDICAL INFORMATION
LONG-TERM CARE PLANNING INFORMATION FORM
(Please complete one of these forms for both client and spouse)

Client: _____ **SSN:** _____ **DOB:** _____

MEDICAL HISTORY (Check box of all that apply and briefly describe)

- Stroke _____ Number _____ Onset Date _____
- Heart Attack _____ Heart Failure _____
- Severe Heart Condition _____ Onset Date _____
- Chronic Respiratory Disorder (e.g. Bronchitis, Emphysema)
- Insulin Dependent Diabetes
- Rheumatoid Arthritis _____ Onset Date _____
- Cancer _____ Onset Date _____

In the past 10 years, I have been diagnosed as having, received medication for or been treated by a medical practitioner for:

- ALS (Lou Gehrig's Disease)
- Alzheimer's Disease: Diagnosis/Onset Date(s)- _____
- Central Nervous System Disease
- Cerebral Palsy
- Crohn's Disease
- Cystic Fibrosis
- Dementia: Diagnosis/Onset Date(s)- _____
- Hepatitis B, or C, Chronic
- Huntington's Disease
- Kidney Dialysis
- Kidney Disease, Chronic
- Liver Disease, Chronic
- Motor Neuron Disease
- Multiple Sclerosis
- Paralysis
- Parkinson's Disease
- Respiratory or Lung Disease, Chronic (other than controlled asthma)
- Ulcerative Colitis

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Any additional pertinent medical information that would be helpful. Please explain: _____

MEDICATIONS _____ Yes _____ No. Are you currently taking any medications? If yes, please provide details in the space below.

Drug Name	Dosage	Frequency of taking	Reason For Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SELF-CARE (I currently need assistance or supervision of another person in performing the following activities):

	No Assistance	Some Assistance	Total Assistance
Bathing	_____	_____	_____
Dressing	_____	_____	_____
Moving in/out of bed or chair	_____	_____	_____
Toileting	_____	_____	_____
Bowel/Bladder Control	_____	_____	_____
Eating	_____	_____	_____
Taking Medications	_____	_____	_____

I currently use (check all that apply):

- Walker
- Respirator
- Motorized Cart
- Wheelchair
- Chairlift
- Oxygen
- Quad Cane (4 pronged cane)
- Dialysis

ADDITIONAL INFORMATION (Briefly describe any other pertinent medical history or conditions that are not addressed above)

