

MEDICAL INFORMATION FORM
THE LIFE CENTER OF DAVIDSON COUNTY

Name of Participant _____ Birth Date _____

Most Recent Date Seen by Physician: _____

MEDICAL DIAGNOSES: Please check: _____ COPD/Respiratory problems
____ Anemia ____ Anxiety Disorder ____ Arthritis
____ Asthma ____ BPH/PSA ____ CAD/Angina
____ CHF ____ Chronic Bronchitis ____ Cancer-Location: _____
____ Dementia ____ Alzheimer's ____ Chronic Renal Failure
____ Emphysema ____ Gastric Ulcers ____ Diabetes: Type I or Type II
____ GERD/Reflux ____ HTN ____ Epilepsy/Seizure Disorder
____ MI/Cardiac ____ Mentally Challenged ____ Parkinson's
____ Defib/Pacer ____ Depression ____ Cardiac Arrhythmias
____ Pneumonia ____ Atrial Fib. ____ Cardiomyopathy

Effects of Stroke: Specify: _____

Skin Disorder: Specify: _____

Psychiatric Issues-Specify: _____

Urinary Problems-Specify: _____

Visual Problems-Specify: _____

Hearing Problems-Specify: _____

ANY OTHER ILLNESSES NOT LISTED ABOVE:

____ YES ____ NO Does the participant have any **COMMUNICABLE** diseases?
If so, specify: _____

____ YES ____ NO Does the participant require constant supervision to make
sure he/she does **NOT** do harm to self, others or to property?

____ YES ____ NO Will this person wander off if not closely attended?

____ YES ____ NO Do you recommend any restrictions for medical reasons on
physical activities such as walking, exercise, etc?
If so, specify: _____

____ YES ____ NO Any **ALLERGIES** to medications, foods or Latex?
If so, specify reactions: _____

____ YES ____ NO Does the participant have difficulty understanding conversations
or communicating needs?

____ YES ____ NO Is the participant at a **HIGH RISK FOR FALLS**?

____ YES ____ NO Participant is at **HIGH RISK OF CHOKING**?

OVER PLEASE

