

New Hampshire Bureau of Developmental Services
HEALTH STATUS INDICATORS

To be used by clinical or support staff to record health-related information and to help communicate recent changes to a supervisor, service coordinator, residential coordinator or health care provider (HCP). Complete prior to annual physical, service coordinator visits and any visit to primary care physician (PCP).

NAME: _____ **DATE:** _____ **ALLERGIES** _____

FILLED OUT BY: _____ **HCP:** _____
Staff Name and Title Health Care Provider

Health Review Checklist	No	Yes	Don't Know	Check If Recent Change
**Highlight or circle changes in health status. Any "Yes," "Don't Know," or "Recent Change" indicates a need for further exploration by the residential coordinator, and may require nurse notification and PCP intervention.				
HABITS: Does this person: 1. Smoke or use tobacco products? 2. Drink alcohol? 3. Avoid regular exercise? 4. Engage in sex?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
SLEEP: Does this person: 1. Have problems sleeping at night? 2. Get up 2 or more times during the night to go to the bathroom? 3. Fall asleep during the day?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
EATING/WEIGHT: Has this person: 1. Gained or lost more than 10 pounds in the past year? 2. Ever choked while eating? 3. Had trouble chewing or swallowing? 4. Cough or had a change in their breathing during or after eating or drinking? 5. Ever been reluctant to eat or drink? 6. Needed to change the texture of their food or drink?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
CARDIO: Does this person: 1. Ever complain of chest, jaw, or left arm pain? 2. Have swollen feet or ankles? 3. Ever have blue lips or nails?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
RESPIRATORY: Does this person: 1. Frequently cough or wheeze? 2. Have shortness of breath when at rest? 3. Have shortness of breath while exercising? 4. Have frequent colds, pneumonia, sinus infections, or bronchitis?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
GASTROINTESTINAL: Does this person: 1. Complain of or appear to have heartburn: rub chest or burp frequently? 2. Vomit 2 or more times per week? 3. Complain of or appear to have abdominal pain? 4. Have a bowel movement less than 3 times per week? 5. Frequently have 3 or more bowel movements per day? 6. Seem to have difficulty moving their bowels? 7. Ever have blood in their bowel movements?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NEUROLOGICAL: Does this person: 1. Have a seizure disorder? 2. Complain of headaches, loss of consciousness, or dizziness? 3. Fall a lot or have difficulty with balance? 4. Walk differently lately? 5. Show a change in what their seizures look like?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			



Health Review Checklist	No	Yes	Don't Know	Check If Recent Change
SKIN & NAILS: Does this person: 1. Have dry skin? 2. Have any rashes, redness, or open sores on their skin? 3. Have any unusual lumps or bumps on or under the skin? 4. Have any unusual marks or moles on the skin? 5. Have problems with fingernails or toenails? 6. Have any blisters or calluses on their feet?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
MOUTH: - Does this person: 1. Have gums that bleed while brushing their teeth? 2. Have any sores in their mouth? 3. Grind their teeth? 4. Have bad breath? 5. Have swollen gums?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
VISION/HEARING: Does this person: 1. Ever have redness or drainage from their eyes? 2. Rub their eyes? 3. Squint? 4. Ever have drainage from their ears or earwax problems? 5. Respond to sound differently lately? 6. Wear a hearing aid or glasses?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
MOBILITY: Does this person: 1. Have trouble using stairs? 2. Have trouble getting around the house? 3. Have difficulty standing, sitting, or bending?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
MUSCULOSKELETAL: Does this person: 1. Complain of or appear to have joint or muscle pain or stiffness? 2. Have a history of broken bones or osteoporosis (brittle bones)? 3. Have any deformities of the feet? 4. Wear special shoes?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
GENITOURINARY: Does this person: 1. Have trouble starting to urinate? 2. Complain of pain or burning during or after urinating? 3. Have urine that has an unusual color or bad odor? 4. Have frequent bladder or kidney infections? 5. Menstruate (have a period)? 6. Experience pain or other behavior changes during their period (menstruation)? 7. Report a change in their menstrual cycle? 8. Ever have any unusual vaginal bleeding or discharge? 9. Ever bleed or have unusual discharge from their penis? 10. Have any lumps or report pain in their groin?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
BEHAVIOR: Currently, does this person ever: 1. Hurt himself/herself or others? 2. Damage property? 3. Appear unusually sad or depressed? 4. Withdraw from others? 5. Display moodiness or irritability? 6. Eat nonfood items? 7. Complain of pain? 8. Have any recent history of personal losses or major life stressors? 9. Display sexually inappropriate behavior? 10. Run or wander away? 11. Appear anxious (nervous, agitated, restless)? 12. Appear forgetful? 13. Repeat words and/or actions again and again?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Notes:

