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# 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

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 |
|---|---|---|---|
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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)

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