ACT Home Health Services, Inc.

MEDICAL HISTORY FORM

Staff Name: _____ **Date Started:** _____

Part A - – Health and Work History

VISION	YES/NO
Do you wear glasses?	
For reading?	
For distance?	
Do you wear contact lenses?	
Are you color blind?	
Do you have?	
Loss of vision	
Retinal disease	
Cataracts	
Glaucoma	
Do you use eye medications?	

HEARING	YES/NO
Do you have?	
Difficulty hearing	
Ear Disease	
Ringing of the ears	
Use a hearing aid	

HEART/ CARDIO	YES/NO
Do you have?	
Chest pain on effort	
High blood pressure	
Shortness of breath	
Swelling of ankles	
Heart murmur	
Have you had?	
Heart attack	
Stroke	
Rheumatic fever	
Heart Failure	
Heart surgery	
Blood vessel surgery	
Do you take medication(s) for your heart, chest pain or high blood pressure?	

GENITO-URINARY	YES/NO
Do you have?	
Kidney trouble	
Bladder trouble	

RESPIRATORY	YES/NO
Do you have	
Chronic cough	
Asthma	
Allergies	
Bronchitis	
Shortness of Breath	
Emphysema	
Have you had?	
Tuberculosis	
Coughed up blood	
Have you ever smoked?	
Number of packs per day	
Number of years	

LIVER/ GASTRO-INTESTINAL	YES/NO
Do you have or have you ever had?	
Liver trouble, Hepatitis	
Cirrhosis	
Jaundice (yellow skin)	
Stomach pains	
Other intestinal problems	
Do you have a hernia?	
Have you ever had surgery for a hernia	

NEUROLOGICAL	YES/NO
Do you have?	
Tremors	
Numbness	
Staggering gait	
Dizzy spells	
Double vision	
Muscle weakness	
Multiple Sclerosis	
Have you had?	
Fits	
Convulsions	
Paralysis	
Are you taking medications for?	
Anxiety or depression	
Epilepsy	

MUSCULO-SKELETAL	YES/NO	MUSCULO-SKELETAL	YES/NO
Have you have?		Have you has surgery on your?	
Back trouble		Back	
Back Pain		Shoulder	
Disc problems		Arm	
Sacro-iliac problem		Wrist	
Shoulder problems/ dislocation		Hand	
Knee problems		Leg	
Swollen joints		Knee	
Arthritis		Ankle	
Rheumatism		Foot	
Frostbite		Have you ever had a job?	
White finger disease		Involving repetitive motion	
Do you have any leisure activities which involve repetitive motion?		Use of vibrating tools	

SKIN	YES/NO
Do you have?	
Eczema	
Skin rashes	
Hives	
Do your skin react to?	
Oils	
Chemicals	
Medicine	
Cosmetics	
Latex	

Please list all medication(s) you are currently taking:

_____

_____

_____

_____

_____

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_____

Do you have a Family Physician/ Telephone Number? _____

Explanation for all your YES responses above: _____

_____

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_____

_____

COVID 19 _____

Did you have ? /_/ Measles /_/ German Measles /_/ Chickenpox /_/ Smallpox /_/ Other: _____

_____ _____

Staff Signature Date

Noted by RN Supervisor: _____ Date: _____