

**Rainbow Homes
Respite/Camp Medical/Health History**



2111 Adelpha Ave., Apt. B Holt, MI 48842
Phone: 517-699-8454 • Fax: 517-699-8454
rainbowhomes@sbcglobal.net
Website: www.rainbow-homes.org
Cell 517-896-3563

Applicant: _____ Age: _____ DOB: _____
Address _____ Seizures: _____
Phone#: _____ Michigan ID#: _____
Allergies: _____ Social Security #: _____
Hospital Preference: _____ Religion: _____

Family Contact Person: _____ Relationship: _____
Address: _____
Phone# _____ Work # _____ Cell# _____
E-mail: _____

Guardianship: _____ Type: _____
Address: _____
Phone# _____ Work # _____ Cell# _____
E-mail: _____

Payee/Conservator: _____ Type: _____
Address: _____
Phone# _____ Work # _____ Cell# _____
E-mail: _____

Insurance Information: Medicaid: _____
Medicare: _____ Part A _____ Part B _____
Drug Plan: ID# _____ Issuer: _____ RX Grp: _____
RXBIN: _____ RXPCN: _____

Other Insurance _____

Medical Diagnosis: _____

Mental Health Diagnosis: _____

Family Doctor: _____ Phone # _____
Address: _____

Dentist: _____ Phone # _____
Address: _____

Doctor: _____ Phone # _____
Address: _____ Specialty _____

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Address: _____ Specialty _____

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Address: _____ Specialty _____

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Address: _____ Specialty _____

Surgeries/past Hospitalizations:(include any Psychiatric hospitalizations)

Reason: _____ Where _____ Date: _____
Reason: _____ Where _____ Date: _____
Reason: _____ Where _____ Date: _____
Reason: _____ Where _____ Date: _____
Reason: _____ Where _____ Date: _____
Reason: _____ Where _____ Date: _____
Reason: _____ Where _____ Date: _____

Medications:

Name _____ Dose: _____ Times: _____ Reason _____
Name _____ Dose: _____ Times: _____ Reason _____
Name _____ Dose: _____ Times: _____ Reason _____
Name _____ Dose: _____ Times: _____ Reason _____
Name _____ Dose: _____ Times: _____ Reason _____

Pharmacy Used: _____

TB Test Date: _____ Results: _____ Tetanus _____

Hepatitis Status: _____

Pneumonia Vaccine: _____ Flu Vaccine _____

Last Mammogram _____ Where: _____ Results _____

Pap: _____ Where: _____ Results _____

Assisted Devices:(include glasses, hearing aides, dentures, braces, etc.)

Equipment: _____ Dr : _____ Date _____
Where Purchased _____

Equipment: _____ Dr : _____ Date _____
Where Purchased _____

Equipment: _____ Dr : _____ Date _____
Where Purchased _____

Equipment: _____ Dr : _____ Date _____
 Where Purchased _____

Diet

Regular _____ Low Fat _____ Low Salt _____ Diabetic _____ Other _____
 Height: _____ Weight: _____ Ideal Weight: _____

Medical History

Please Circle all that apply:	Yes	No	When
Measles or German Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis or Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone or joint disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bursitis or Sciatic Nerve	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Meningitis/Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High/Low Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/environmental Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies to medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies to food	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies(bee sting, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____

Smokes: Yes/ No Age started _____ How many packs/a day _____
 Chews Tobacco: Yes/No Age Started _____

Alcohol Occasionally _____ Frequently _____ Social drinker _____
 Problem drinker _____ Police involvement _____
 Explain: _____

Immunizations:	Yes	No	Approximate Date
Small Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria-Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flu vaccine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family Medical History

The following history is necessary to provide the best medical care for the individual. All information is kept confidential and used only to provide health information to the provider caring for the individual.

Individual is adopted _____ No family history is known _____

Father _____ Age _____ Living _____ Age of Death _____ Cause _____

Mother _____ Age _____ Living _____ Age of Death _____ Cause _____

Brother and/or sisters

_____ Age _____ Living _____ Age of Death _____ Cause _____

_____ Age _____ Living _____ Age of Death _____ Cause _____

_____ Age _____ Living _____ Age of Death _____ Cause _____

_____ Age _____ Living _____ Age of Death _____ Cause _____

_____ Age _____ Living _____ Age of Death _____ Cause _____

_____ Age _____ Living _____ Age of Death _____ Cause _____

Has Any Blood Relative had any of the following (please indicate maternal or paternal side)

Cancer _____

Tuberculosis _____

Diabetes _____

Heart Disease _____

High Blood Pressure _____

Stroke _____

Epilepsy _____

Blood disorders _____

Psychiatric disorder _____

Alcoholism _____

Drug abuse _____

Depression _____

Kidney Disease _____

Any other medical, health or genetic information that may help diagnosis future health issues: _____
