My Medical Conditions and Care Needs

Use this form to keep track of your medical conditions, care needs, and preferences.

- Talk with your doctor and get help from someone you trust when filling it out.
- Make copies of this form to share with people who know about your emergency preparedness plans.
- You can also give a copy to first responders, or other people who may help you during an emergency.

You may also want to consider allowing a caregiver or someone you trust access to your medical information stored in your patient portal. A patient portal is a secure online website that provides 24-hour access to your personal health information from anywhere with an Internet connection. To grant access to your portal health record, check with your primary care physician. Some portals allow you to set up a proxy account online.

Use a computer to fill in the form, or print the form out and write on it.
To download this form separately, go to the NADRC.acl.gov website.

Personal Information

Name

Preferred name: Phone:

Address:

Date of birth Blood type:

Primary language:

Contacts

Contact	Name	Address	Contact number
Emergency contact:			
Primary care physician:			
Pharmacy:			
Paid caregiver contact:			
Synagogue, church, mosque, or other faith community			

Conditions or Symptoms Related to Dementia

Do you think you might have dementia, or have you been diagnosed with dementia (such as Alzheimer's disease, vascular dementia, Lewy body dementia, or frontotemporal degeneration)?

Do you have any of the following symptoms of dementia, or has someone who cares about you noticed any of these symptoms? (Check all that apply)

- ☐ Difficulty finding the right words or understanding others
- ☐ Difficulty planning or problem solving
- ☐ Slowed thinking or difficulty concentrating
- ☐ Changes in mood or personality
- ☐ Irritability or angry outbursts
- ☐ Confusion with time or place
- ☐ Indifference to important events or people
- ☐ Difficulty recognizing familiar people or objects
- ☐ Impulsive behavior
- ☐ Signs of unsafe driving (e.g., failing to observe traffic signs, making slow or poor decisions in traffic)
- ☐ Believing something that is not true or falsely accusing others
- ☐ Seeing things or people that aren't there
- ☐ Balance problems, shuffling walk, or frequent falls.
- ☐ Tremor or shaking, most commonly at rest
- ☐ Sleep problems (e.g., problems with sleep/wake cycle, vivid nightmares, or physically moving around during sleep)
- ☐ Changes in eating habits or diet such as binge eating or eating inedible objects
- ☐ Other:

When do these symptoms occur? What helps you? Explain below

Other Medical Conditions

Allergies (including medications, foods, environmental, or pets):

Do you have any problems seeing or hearing, or other conditions that might make it hard to communicate?

List your current medical conditions (such as diabetes, chronic obstructive pulmonary disease [COPD], arthritis):

Do any of your medical conditions require ongoing management and care by a physician or other health care provider? If so, describe the type of care you need (such as medication, physical therapy, regular doctor visits):

Have you had any falls in the last 12 months? ☐ Yes ☐ No

Do you feel unsteady on your feet? ☐ Yes ☐ No

Past surgeries (date and type of surgery):

Do you have a pacemaker, heart monitor, or any other implanted device?

List of Vaccinations and Most Recent Date Received

Vaccination	Date
Influenza:	
Tdap/Td (Tetanus):	
Pneumococcal:	
Shingles:	
COVID-19 vaccinations and booster if applicable:	

Vaccination	Date
Chicken Pox:	
Measles:	
Hepatitis A/B/C:	
Other:	
Other:	

Current Medications

Prescribed and over-the-counter medications and herbal remedies

Medication	What is it for?	When was it first prescribed?	Dosage	Frequency	How is it taken?

Assistive Devices

Check all that apply:

- ☐ Glasses
- ☐ Hearing aids
- ☐ Dentures
- ☐ Communication board or other communication device, if you are unable to communicate using your voice
- ☐ Cane or walker
- ☐ Wheelchair
- ☐ Motorized wheelchair or scooter
- ☐ Personal location device (GPS, tracking device)
- ☐ Shower bench
- ☐ Raised toilet seat
- ☐ Portable oxygen

Other:

Other:

Write down the model information of any assistive medical devices, and whether they are covered by insurance (Medicaid, Medicare, private insurance, etc.):

Note: Be sure to label each of these items with your name, address, and phone number. Any person assisting you should be trained on how to use any assistive devices.

Service Animal

Do you receive assistance from a service dog? ☐ Yes ☐ No

What is the dog's name?

If yes, is the dog registered or licensed, and does it wear identification? ☐ Yes ☐ No

Describe the type of assistance provided by the service dog:

Care Needs

Do you need help with:

- ☐ Walking
- ☐ Eating
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Medication

Describe the type of help you need, how often, time of day, and who helps you:

Do you have bowel or bladder incontinence? ☐ Yes ☐ No

If so, how is it managed?

Do you use disposable briefs? ☐ Yes ☐ No

Special Dietary Needs (such as a diabetic diet, low salt, soft or pureed foods)

Describe:

Favorite foods/snacks:

Personal Information

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Life Partner

Relationship	Name and phone number
Spouse	
Children	
Grandchildren	
Brothers or sisters	
Significant others and friends	
Paid caregiver(s)	

Who visits most often, or knows the most about you?

Describe any regular or daily routines:

Sleep habits (be specific, including wake up time, bedtime, naps, what helps with sleep difficulties, bedtime routine):

Favorite activities or hobbies:

List any important life events, good or bad, including past trauma that may be helpful to know:

Reset Form