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 disaster plans.
- You can also give a copy to first responders, or other people who help you during a disaster.

To learn more about creating and storing a personal health record including this form, go to https://www.myphr.com/resources/choose.aspx.

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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 website.

Personal information

Today's date:

Name:

Preferred name: Phone:

Address:

Date of birth: Blood type:

Primary language:

Contacts

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

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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 (i.e., 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
- ☐ Sleep problems (i.e., 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:

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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 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):

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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 Date Received

	Date
Influenza	
Tdap/Td (Tetanus)	
Pneumococcal	
Shingles	

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

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Current Medications

Prescribed and over-the-counter and herbal remedies

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

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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
- ☐ Walker
- ☐ Wheelchair
- ☐ Motorized wheelchair or scooter
- ☐ Personal location device (GPS, tracking device)
- ☐ Shower bench
- ☐ Raised toilet seat
- ☐ Portable oxygen
- ☐ Other:
- ☐ Other:

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 special equipment and how to assist in an evacuation.

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

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Service Dog

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

What is the dog's name?

If so, is the animal registered or licensed, and do they wear identification?

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? If so, how is it managed?

Do you use disposable briefs? ○ Yes ○ No

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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

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	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: