Name: _____

Medical History: Please check all that apply

☐ Anemia	☐ Frequent or severe headaches	☐ Pain/pressure in chest
☐ Anxiety	☐ GERD	☐ Palpitations
☐ Arthritis	☐ Glaucoma	☐ Paralysis
☐ Asthma	☐ Hearing Impairment	☐ Prostate Problems
☐ Cancer – **Type**_____	☐ Hepatitis	☐ Rheumatic Fever
☐ Chronic Obstructive Pulmonary Disease	☐ HIV/AIDS	☐ Seizures
☐ Clotting Disorder	☐ High Cholesterol	☐ Shortness of Breath
☐ Congestive Heart Failure	☐ Hypertension	☐ Skin Conditions
☐ Diabetes - Insulin Dependent **Y** or **N**	☐ Hypotension	☐ Stroke
☐ Dementia	☐ Hypoglycemia	☐ Stomach Problems
☐ Depression	☐ Hemodialysis	☐ Thyroid Problems
☐ Dizziness	☐ Hepatitis	☐ Tuberculosis
☐ Emphysema	☐ Intestinal Problems	☐ Urinary Infections
☐ Epilepsy	☐ Kidney Disease	Other: _____
☐ Eye Problems	☐ Liver Problems	_____
	☐ Mental Retardation	_____

Social History

☐ Smoke Packs/Day_____ # of years _____	☐ Drink Alcohol Type/Frequency _____

Surgical History

Please list names and dates of surgeries: _____

_____

_____

Devices & Prosthesis

☐ Artificial Heart Valve ☐ Artificial Joint Implant If yes, please describe_____ _____ ☐ Catheter ☐ Contact Lens	☐ Glasses ☐ Hearing Aids ☐ Pacemaker Other: _____ _____

Adult Day Center of Somerset County, Inc., 872 East Main Street, Bridgewater, NJ 08807,
phone: 908-725-0068, *fax:* 908-725-2995, www.adultdaycenter.org

Please include any additional information that you think would be beneficial to the Adult Day Center Staff:

Completed by: _____ Date: _____

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