

**New Hampshire Continua of Care
MEDICAL INFORMATION Data Collection Form for HMIS**

*(Complete for each client entered into your program, * means required)*

1. First, Mi. Last Name: _____	2. Alias: _____
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<u>General Health Information</u>	
3. General Health Status:* <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Don't Know	4. Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____ _____ _____ _____ _____
5. Receiving Medical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Last Visit: ____/____/____ 7. Next Appt: ____/____/____ - ____:____ 8. Is On Disability / SSI: <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Have Medical Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Use Wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Doctor in the Community: <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name: _____ Telephone: _____	12. Pregnant:* <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Due Date:* ____/____/____ 14. In Prenatal Care Now: <input type="checkbox"/> Yes <input type="checkbox"/> No 15. Where: _____ 16. Telephone: _____ 17. Next Appt: ____/____/____ - ____:____ 18. Last /Most Recent Appt: ____/____/____ Needs help with; 19. Dressing/Bathing: <input type="checkbox"/> Yes <input type="checkbox"/> No 20. Chores/Shopping: <input type="checkbox"/> Yes <input type="checkbox"/> No 21. Special Equipment Needed: _____ _____

<u>Tuberculosis Screening Sub-Assessment</u>	
22. Latest TB Test: ____/____/____ <input type="checkbox"/> Unknown 23. Was TB Test Result Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No 24. Last Chest X-Ray Taken: ____/____/____ 25. Did you Take TB Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	26. Have you Experienced Any of the Following: <input type="checkbox"/> Prolonged Cough <input type="checkbox"/> Chills <input type="checkbox"/> Chest Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight Loss <input type="checkbox"/> Cough up Blood <input type="checkbox"/> None

<u>Medication Overview Sub-Assessment</u>						
27. Medications:	Physician:	Pharmacy:	Telephone:	Verified:	Prescript. Date:	Exp Date:
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____	____/____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____	____/____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____	____/____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____	____/____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____	____/____
					MM / Y Y	MM / Y Y

Mental Health Sub-Assessment

28. Did You Ever Need Counseling or Mental Health Care: Yes No
If Yes:

When Treated: ___/___/___ to ___/___/___

Provider/Counselor: _____

Facility Telephone: _____

Did You Ever Need Medication for Mental Health: Yes No

Did You Ever Need Medication For ADHD: Yes No

Did You Ever Need Special Education: Yes No

Next Appt: ___/___/___ - ___:___

Last/Most Recent Appt: ___/___/___

29. General Presentation:

- Pleasant
- Agitated
- Involuntary Movements
- Psychomotor Retardation
- Slow Moving
- Distractible
- Guarded
- Angry
- Sad
- Cooperative

Substance Abuse Sub-Assessment

30. Drug/Alcohol Problem: Yes No

31. Ever in Treatment / Detox: Yes No

32. When: ___/___/___

33. Where: _____

34. Age of first Drug/Alcohol Usage or Pick Up: _____

35. Longest Period Sober: _____

Plan/Referrals Sub

36. Medical Referral: Yes No

37. Mental Health Referral: Yes No

38. Substance Abuse Referral: Yes No

Date completed: ___/___/___

Initials _____