Advocate Medical Group

NEW PATIENT HEALTH QUESTIONNAIRE
ADULT DOWN SYNDROME CENTER || ADVOCATE LUTHERAN GENERAL HOSPITAL

Date of Appointment _____

ALL QUESTIONS REFER TO THE PERSON WITH DOWN SYNDROME

Name _____ Date of Birth _____

Person Filling Out the Form: _____

Do you have any specific concerns regarding new or ongoing health/behavioral issues about the person with Down syndrome? (Please write in the space below. Use another sheet of paper if necessary).

_____

_____

SAFETY ISSUES:

Are there safety issues that have affected or impacted his or her daily routine (i.e. sex, physical abuse, etc.)?
If so, please describe:

_____

_____

_____

REVIEW OF SYSTEMS:

BEHAVIOR, FEELINGS AND MEMORY

Has the patient had trouble remembering things or been forgetful? Yes _____ No _____

Can the patient learn to do new things? Yes _____ No _____

Stopped being able to do things he or she used to be able to do? Yes _____ No _____

Had any change in his or her usual behavior or outlook on life? Yes _____ No _____

Had any change in his or her interest in life or activities? Yes _____ No _____

Seemed sad or withdrawn? Yes _____ No _____

Are there concerns about how the patient is acting or feeling? Yes _____ No _____
If yes, please describe:

_____

_____

_____

PHYSICAL PROBLEMS

EATING, DRINKING AND WEIGHT

Does the patient have any problems with sucking, chewing, swallowing, or choking or any dietary issues? Yes _____ No _____

If yes, please explain:

_____

_____

Are there any dietary-related diagnoses, such as:

- Celiac disease Yes ____ No _____
- Lactose intolerance Yes ____ No _____
- Diabetes Yes ____ No _____
- Nut allergy Yes ____ No _____
- Other Yes ____ No _____

Has the patient had any change in their weight? Yes ____ No _____

If yes, please explain:

_____

_____

How much weight loss or gain? _____

Over what length of time? _____

BATHROOM

Is the patient having difficulty with pooping or constipation? Yes _____ No _____

If yes, how often does this occur? _____

Is the patient having accidents with stool (poop)? Yes _____ No _____

Having difficulty with frequent diarrhea? Yes _____ No _____

Is the patient having accidents with urine? Yes _____ No _____

WALKING

Does the patient have difficulty walking? Yes _____ No _____

Does he or she fall frequently? Yes _____ No _____

Does he or she have any loss of balance? Yes _____ No _____

Does he or she use any adaptive devices, such as a wheelchair, walker, ankle-foot orthotic (AFO), etc? Yes _____ No _____

If yes, please specify _____

Other issues with walking? _____

ENDOCRINE

Has a medical person ever said that the patient has a thyroid problem? Yes _____ No _____

If yes, has the medical person said the thyroid is underactive (working too little) or overactive (working too much)?

Underactive _____ Overactive _____

Has the patient ever been diagnosed with diabetes mellitus (sugar problems)? Yes _____ No _____

Has he or she been drinking more liquids recently? Yes _____ No _____

Recently been urinating more? Yes _____ No _____

NEUROLOGIC

Has the patient ever had seizures (spasms, convulsions)? Yes _____ No _____

Does the patient have any other neurological issues (i.e., Alzheimer's disease, multiple sclerosis, stroke, etc)? Yes _____ No _____

If yes, please explain:

_____

_____

SLEEP

Does the patient seem more tired? Yes _____ No _____

Has the patient been diagnosed with a sleep disorder? Yes _____ No _____

If yes, please explain:

_____

What time does the patient go to bed? _____

What time does the patient get up? _____

Estimated sleep time? _____ hours

SKIN

Does the patient have dry skin? Yes _____ No _____

Does he or she use creams or lotions? Yes _____ No _____

Are there any other skin problems? Yes _____ No _____

If yes, what type?:

_____

EYES

Does the patient wear glasses? Yes _____ No _____

Does he or she wear contacts? Yes _____ No _____

Any other problems with seeing (i.e. cataracts, keratoconus, glaucoma)? Yes _____ No _____

If yes, please specify:

_____

EARS

Does the patient have difficulty hearing in daily life? Yes _____ No _____

Has a hearing problem been found on a previous hearing test? Yes _____ No _____

Does the patient have hearing aids? Yes _____ No _____

If yes, please specify type:

_____

Right ear _____ Left ear _____ Both ears _____

Does he or she have problems with buildup of earwax? Yes _____ No _____

Have frequent ear infections? Yes _____ No _____

Eardrum perforations? Yes _____ No _____

If so, which ear: Right ear _____ Left ear _____ Both ears _____

Ear tubes? Yes _____ No _____

If so, which ear: Right ear _____ Left ear _____ Both ears _____

NOSE AND SINUSES

Does the patient have a frequent runny nose? Yes _____ No _____

Does he or she have sinus problems? Yes _____ No _____

Does he or she have seasonal or environmental allergies? Yes _____ No _____

MOUTH

Does the patient have teeth or gum problems? Yes _____ No _____

Does he or she wear dentures? Yes _____ No _____

Brush his/her teeth daily? Yes _____ No _____

Floss his/her teeth regularly? Yes _____ No _____

Does he or she see a dentist? Yes _____ No _____

If yes, how often?:

_____

LUNGS

Does the patient get frequent pneumonia? Yes _____ No _____

Get frequent bronchitis? Yes _____ No _____

Have a persistent cough? Yes _____ No _____

Has the patient been diagnosed with any lung problems, such as asthma, chronic obstructive pulmonary disease (COPD), etc.? Yes _____ No _____

If so, please specify _____

CARDIAC

Has the patient had any heart problems? Yes _____ No _____

If yes, what type?

_____

Was the patient told to take medicine to prevent heart infections when going to the dentist? Yes _____ No _____

ORTHOPEDIC

Has the patient ever had neck x-rays? Yes _____ No _____

If yes, when?

_____

Were there any problems found on the x-rays? Yes _____ No _____

GENITAL
For Women

Has the patient ever had a period? Yes _____ No _____

Age periods began? _____

How often does she get her period? _____

How many days do her periods last? _____

When was her last menstrual period? _____

Is she sexually active? Yes _____ No _____

Is birth control needed? Yes _____ No _____

Is birth control currently being used? Yes _____ No _____

Has she ever been pregnant? Yes _____ No _____

Has she ever had a pap smear? Yes _____ No _____

If yes, what was the date of last pap smear? _____

If yes, has she ever had an abnormal pap smear? Yes _____ No _____

Has she ever had a mammogram? Yes _____ No _____

If yes, what was the date of last mammogram? _____

If yes, has she ever had an abnormal mammogram? Yes _____ No _____

For Men

Is the patient sexually active? Yes _____ No _____

Does he have an undescended testicle? Yes _____ No _____

Does he have a hernia in the groin area? Yes _____ No _____

MEDICATIONS

Please list all prescription medications, over-the-counter medicines, natural products and vitamins or supplements the patient is taking. Please include topicals and skin care products. If you are not sure, bring the bottles of medicine to show the doctor.

Name	Dose	When Started

ALLERGIES

Has the patient ever been told they are allergic to food, medicine, animals or things outdoors? Yes _____ No _____

If yes, please list:

_____

MEDICAL HISTORY

Has the patient been admitted to a hospital or had an operation? Yes _____ No _____

If yes, please list the date, the hospital and the reason (use another piece of paper if necessary)

Date	Hospital	Reason

Has the patient seen another health person who said they have a medical problem (i.e., asthma, gout, etc)? Yes _____ No _____

If yes, list the medical problem(s) below?

_____

_____

_____

IMMUNIZATIONS

Please complete the following immunization record for the patient. If you are not sure, please bring the patient's immunization record.

When was his/her last diphtheria/tetanus/pertussis (Tdap) or diptheria/tetanus (TD) shot?

_____

Has he or she ever received the hepatitis B vaccine series? Yes _____ No _____

Has he or she ever had chickenpox disease? Yes _____ No _____

Has he or she ever had the chickenpox vaccine? Yes _____ No _____

Does he or she get the flu shot each fall? Yes _____ No _____

Has he or she ever had the pneumonia vaccine? Yes _____ No _____

If yes, when? _____

Has he or she ever had the Gardasil vaccine? Yes _____ No _____

Has he or she ever had the Menactra (meningitis) vaccine? Yes _____ No _____

If yes, when? Date of 1st Dose _____ 2nd Dose _____

Has he or she ever had the Zostavaox (shingles) vaccine? Yes _____ No _____

HEALTH CARE PROVIDERS

Please list the names of any other people that the patient sees for his/her health care.

Name	Speciality or Type of Provider

FAMILY MEDICAL HISTORY

Please check the box of everyone in the family of the patient who had any of the following health problems.

Conditions in the family	Who had it or currently has it?			
	Mother	Father	Sibling	Other
Arthritis	❑	❑	❑	❑
Dementia or Alzheimer's disease	❑	❑	❑	❑
Depression or other mental illness	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Down syndrome	❑	❑	❑	❑
Heart disease	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
High cholesterol	❑	❑	❑	❑
Seizures	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑
Cancer (i.e., breast, leukemia, etc.)				
Please specify type: _____	❑	❑	❑	❑
_____	❑	❑	❑	❑
_____	❑	❑	❑	❑
_____	❑	❑	❑	❑
Alcohol abuse	❑	❑	❑	❑
Drug abuse	❑	❑	❑	❑
Other (which condition?) _____	❑	❑	❑	❑

HABITS

Please answer these questions for the patient:

Has he or she ever smoked? Yes _____ No _____

If yes, how much? _____ If quit, when?_____

Does he or she drink alcohol? Yes _____ No _____

If yes, how much? _____ If quit, when?_____

Does he or she use recreational/illegal drugs? Yes _____ No _____

If yes, how much? _____ If quit, when?_____

EXERCISE

Does the person with Down syndrome participate in regular exercise or times when they play sports, walk, swim or run? Yes _____ No _____

If yes, please specify:

Type of exercise	How often	How long per time

OCCUPATION/SCHOOL

Is the patient currently enrolled in school? Yes _____ No _____

If yes, what is the name of the school? _____ Grade level?_____

Does the patient have a job right now? Yes _____ No _____

If yes, what is the name of the job site? _____

What are the job duties? _____

If not presently working, what did they do in the past?

_____

RESIDENCE

Where does the patient live (please mark one)

❑ Family home
❑ Own home
❑ Group home

If in a group home is it a:

❑ Community Integrated Living Arrangement (CILA) house
❑ ICF-DD
❑ Supported Living Arrangement (SLA) apartment
❑ Other Please specify: _____

Number of people in the group home:_____

SOCIAL INFORMATION

Please answer these questions about the family household regardless of where the patient currently lives.

1. Parents

Name	Age	Relationship to patient	Ethnicity	Occupation

2. Siblings living in household

Name	Age	Marital Status	Children

3. Siblings not living in household

Name	Age	Marital Status	Children

4. Other relatives living in household

Name	Age	Marital Status	Children