North Carolina
Department of Health & Human Services
Division of State Operated Healthcare Facilities
Developmental Centers

DEVELOPMENTAL CENTER ADMISSION APPLICATION
Medical History

DATE of Completion: NAME: DATE OF BIRTH:
Height: Weight:

PERSONAL HISTORY

Has the Individual ever had any of the following? If yes, indicate year of first occurrence.

	Yes	No	Year
High blood pressure	☐	☐	
Rheumatic fever	☐	☐	
Heart problems	☐	☐	
Chest Pain	☐	☐	
Asthma	☐	☐	
Pneumonia	☐	☐	
Chronic cough	☐	☐	
Thyroid Disorder	☐	☐	
Diabetes	☐	☐	
Seizures	☐	☐	
Fainting Spells	☐	☐	
Severe Head Injury	☐	☐	
Obesity	☐	☐	

	Yes	No	Year
Hay Fever or Sinus problems	☐	☐	
Arthritis	☐	☐	
Gout	☐	☐	
Kidney Disease	☐	☐	
Kidney Stones	☐	☐	
High Cholesterol	☐	☐	
Reflux/heartburn	☐	☐	
Constipation	☐	☐	
Frequent vomiting	☐	☐	
Cancer (specify)	☐	☐	
Radiation or chemotherapy	☐	☐	
HIV/AIDS	☐	☐	
Hepatitis A, B, C	☐	☐	

	Yes	No	Year
Jaundice	☐	☐	
Immune System disorder	☐	☐	
Blood transfusion	☐	☐	
Bleeding disorder	☐	☐	
Sickle Cell Anemia	☐	☐	
Anemia - Other	☐	☐	
Glaucoma	☐	☐	
Skin Breakdown/ Decubitus	☐	☐	
Pica	☐	☐	
Weight Bearing Problem	☐	☐	
Unsteady Gait	☐	☐	
Falls	☐	☐	
Broken bone (specify)	☐	☐	
Osteoporosis/ Osteopenia			

	Yes	No	Year
Hernia	☐	☐	
Testicle or Prostate problems	☐	☐	
Severe menstrual cramps	☐	☐	
Irregular Menses	☐	☐	
Anorexia/Bulimia	☐	☐	
Depression	☐	☐	
Bipolar Disorder	☐	☐	
Attempts at Self-Harm	☐	☐	
Other Mental Illness	☐	☐	
Use of tobacco products	☐	☐	
Sexual Activity	☐	☐	
Pregnancy	☐	☐	
Sexually Transmitted Disease	☐	☐	
Other (Specify)			

Childhood diseases: measles/yr mumps/yr chicken pox/yr rubella/yr other/yr

FAMILY HISTORY

Has any person, related by blood, had any of the following?

	Yes	No	Relationship
High blood pressure	☐	☐	
Stroke	☐	☐	
Heart attack before age 55	☐	☐	
Blood or clotting disorder	☐	☐	

	Yes	No	Relationship
High Cholesterol	☐	☐	
Diabetes	☐	☐	
Glaucoma	☐	☐	
Cancer (type)	☐	☐	

	Yes	No	Relationship
Cancer (type):	☐	☐	
Alcohol/drug problems	☐	☐	
Psychiatric illness	☐	☐	
Suicide (or Attempted)	☐	☐	

Previous Hospitalizations/Surgeries/Serious Injuries/Serious Illnesses Please list:

Year	Hospitalization, Surgery, Serious Injury, Illness	Reason

Seizures:

Description	
Frequency and Duration:	Date of Last Seizure:

Mobility	Other Physical or Equipment Needs
Ambulatory ☐ Yes ☐ No Mobility Equipment Needs: ☐ Wheelchair ☐ Walking Gait Belt ☐ Walker ☐ Crutches ☐ Splints/Braces Type Other Transfers with assistance? ☐ Yes ☐ No (If Yes, specify): ☐ Mechanical Lift Transfer ☐ 2-Person Lift Transfer ☐ Stand Pivot Transfer	☐ Corrective lenses ☐ Hearing Aid(s) ☐ Dentures ☐ Bedrails ☐ Bathing Table ☐ Breathing Treatment ☐ Nebulizer ☐ C Pap ☐ Other(Specify):

Current Medications: List all medications the individual is currently taking; prescribed, over-the-counter and supplements (i.e. vitamins), including frequency and dosage amount.

Medication	Dosage	Route	Frequency	Indication/Reason

MEDICATION ADMINISTRATION

Cooperative in Taking Medications? ☐ Yes ☐ No Does Individual Self-Administer Medications? ☐ Yes ☐ No

Medications Administered By:

☐ Oral (Swallows with water)
☐ Crushed in: ☐ Thickened Fluids ☐ Pudding ☐ Preferred Beverage
☐ Applesauce
☐ By Tube (Specify G or J)
☐ Other (please explain)

Describe Individual's Participation in Medication Administration:
Adaptive Equipment For Medications:

Diagnostic Tests: Indicate below

Test	Reason For Test	Year	Facility	Results
EGD/Endoscopy				
Colonoscopy				
CT Scan – Brain				
CT Scan – Abdomen				
CT Scan – Other (Specify)				
MRI Scan – Brain				
MRI Scan – Other (Specify)				
EEG				
EKG				
Other				

Is Individual Cooperative With Medical Procedures : Such as drawing blood, physical exam, dental exams? ☐ Yes ☐ No
If No, do they exhibit (check those that apply) ☐ Non-Compliance ☐ Aggression ☐ Self-Injurious Behavior

Do Reinforcers Help? ☐ Yes ☐ No
If Yes, what are preferred reinforcer items?

Does the Individual require sedation for exams or medical procedures? ☐ Yes ☐ No
If yes, please list medication and dosage previously used (if known).

Does the Individual have any allergies to medications? ☐ Yes ☐ No
If yes, please list and explain type of reaction (ex. rash; hives; serious life-threatening reaction requiring emergency treatment; etc).

Medication Name	Type of Reaction

Does the Individual have any food or other allergies (eggs,chicken, gelatin, feathers, latex, bee stings, etc.)? ☐ Yes ☐ No

If yes, please list and explain type of reaction.

Allergy	Type of Reaction

What are current diet consistency/calories? ☐ *Regular* ☐ *Chopped* ☐ *Pureed* *Calories:*

Does the Individual eat independently? ☐ Yes ☐ No (requires assistance)

ADE (adaptive dining equipment) used/needed? ☐ Yes ☐ No Specify:

Does the Individual have a history of choking? ☐ Yes ☐ No

Has the Individual had a swallowing study? ☐ Yes ☐ No Date:

Does the Individual aspirate or had aspiration pneumonia? ☐ Yes ☐ No
Does the Individual have braces on his/her teeth? ☐ Yes ☐ No
Has the Individual been treated for osteoporosis? ☐ Yes ☐ No

If yes, list bisphosphonates or other medication if known:

Does the Individual have a feeding tube? ☐ Yes ☐ No

Type of Feeding Tube: Date Last Replaced:

Feeding Formula and Frequency:

Any Special Information:

Age of First Menstrual Period (if applicable)?

Requires assistance with menstrual care? ☐ *Yes* ☐ *No* *Please give details (i.e. can acquire supplies, needs assistance, reminders to wash hands, other)*

Pain medications used for menstrual cramps? ☐ *Yes* ☐ *No*

Irritability associated with period? ☐ *Yes* ☐ *No*

Date of Last Menstrual Period:

Continent of Bowel and Bladder? ☐ Independent ☐ Wears Disposable Products ☐ Catheter

If not independent, please describe assistance needed: (i.e. assistance to ensure thorough cleaning, reminders to wash hands):

Average # of Hours of Sleep:

Care Received In The Past Year: List physicians, clinics, dentists, psychiatrists/therapists who have seen the Individual in the past year, with address and phone number if known.

Name/Clinic	Address	Phone Number