SCOPE:

Community Home Directors
Family Living Home Directors
County Mental Health/Mental Retardation Administrators
County Mental Health/Mental Retardation Case Managers
Non-licensed Support Service Provider Directors

PURPOSE:

The purpose of this bulletin is to transmit information regarding:

1) The recommended composition and maintenance of a lifetime medical history for individuals being served.

2) The essential nature of medical histories to ensure quality health care delivery to people with disabilities.

3) Optimal procedures for constructing a comprehensive lifetime medical history for each individual with mental retardation for whom they are providing services.

4) Technical assistance for the construction of an accurate and useful lifetime medical history, regardless of resources.

BACKGROUND:

The lack of a uniform, comprehensive lifetime medical history has sometimes resulted in the inability and reluctance of medical professionals to treat individuals with mental retardation as well as a lack of information available to staff who are providing support. Medical information is often lost over time, buried in volumes of records, passed by word of mouth between staff, and between staff and medical professionals. Information about past medical history has thus become irretrievable and not available to medical professionals. The least consequence of this situation is reluctance to treat people with mental retardation and at worst, disastrous medical treatment due to a lack of medical information.

REFER COMMENTS AND QUESTIONS TO:

APPROPRIATE MENTAL RETARDATION REGIONAL PROGRAM MANAGER
A comprehensive lifetime medical history for each individual serves to provide the background and the foundation for appropriate health care as well as providing appropriate support to staff. This medical information should be made available to all medical professionals who need to know this information in order to provide quality health care, e.g., primary care physicians, consultants, clinics, and emergency room physicians. The medical information contained in the lifetime medical history should also assist staff in understanding the individuals they support.

Finally, the information contained within the lifetime medical history provides one of the most comprehensive descriptors of the individual's medical information. The confidentiality of this information must be respected.

GUIDELINES:

1. The Lifetime Medical History provides a comprehensive historical overview of the person. Documentation of past medical/dental information, psychological and social well being, and functional abilities are integral parts of the document.

2. The lifetime medical history should be constructed from past and present documentation by a trained medical professional, such as a nurse, a nurse practitioner or a physician. In the absence of funding for medical professionals, agency personnel could construct the lifetime medical history, later obtaining the approval of a medical professional for the content. It is important that a medical professional review the document to ascertain the accuracy of the information contained therein.

3. The lifetime medical history should be updated yearly by an agency designee and approved by the physician at the time of the annual physical. It is recommended that the lifetime medical history be revised and updated every three to five years by a medical professional. Alternatively, information from the previous three to five yearly updates could be incorporated into the document by agency staff with the signed review of a medical professional. Revisions and updates should become easier once the initial summary is constructed.

4. The initial lifetime medical history as well as yearly addendum, and subsequent updates should be provided to the individual's primary care physician and specialists.

5. A copy of the lifetime medical history summary should be kept with the individual's emergency medical information and accompany the individual in the event of the use of emergency medical services.

6. It is recommended that the lifetime medical history be divided by a review of body systems because this is the way in which physicians will review an individual's current medical status. Other systems of organization may be feasible depending upon the authorship of the document. However, all of the information should be included to compose a complete lifetime medical history.
7. The Lifetime Medical History Summary should include the following sections:

a. Overview of Current Status:
   i. Basic identifying information
   ii. Etiology of disability
   iii. Long term chronic health conditions
   iv. Functional status: hearing, vision, communication ability, gross and fine motor development
   v. Behavioral characteristics
   vi. Amount of supervision in residential living situation, e.g., if a person lives independently, the physician must be certain that the individual is informed as to how to do any necessary treatments

b. Developmental History

c. Family/Social Information

d. Past Medical History: This information should be organized by "review of body systems" which is the standard method of physical assessment used by physicians.

e. Psychiatric/Behavioral

f. Dental

g. Current Medical Status

h. Immunizations
   i. Hepatitis B Status
   ii. TB Status
   iii. Date of last Tetanus and Diphtheria
   iv. Other

i. Allergies/Sensitivities

j. Medications

8) Information from past placements and hospitalizations should be included in the Summary, as well as information from family, friends, staff, and the individual.

9) The Medical History Summary should be a brief synopsis, not more than three pages, which will quickly and clearly provide a comprehensive description of the person.

10) The Medical History Summary is a confidential document and intended to be read only by those who "need to know" in order to provide medical care to an individual.

A sample Lifetime Medical History Summary is attached for your reference.

* Review of Body Systems
  Eye, Ear, Nose, Throat
  Respiratory
  Cardiovascular
  Digestive/Gastrointestinal
  Kidney, Urinary Tract, and Reproductive
  Neurologic
  Musculoskeletal
  Endocrine
  Lymphatic
  Skin, Hair, Nails
Elizabeth Collins
Address:

DOB: 6/12/24
SS#:

Primary Physician:
Dr. Frank Miller, M.D.  Address
Phone:

Dentist:
Dr. John Brady, DDS  Address
Phone:

Overview:
Elizabeth (Liz) is a 69 year old white female who is diagnosed as mildly mentally retarded. She has angina, cardiomyopathy, hypertension, non-insulin dependent diabetes and osteoarthritis. Liz has adequate vision with corrective lenses and she has normal hearing. She is fully ambulatory and travels about independently in the community.

Liz lives with a long time friend who has physical disabilities and is very helpful and supportive of her. She is independent in all self-care and household tasks. Liz schedules her own medical appointments, has her prescriptions filled and takes her medications reliably.

Developmental Information:
Liz is one of 10 children, all of whom were described in Pennhurst intake information as "mentally defective." Liz was slow in learning to walk with speech not appearing until the age of 5. She had whooping cough before the age of 6 and remembers having chicken pox and scarlet fever as a child.

Family / Social Information:
Liz was the 5th of 10 children, all diagnosed with various levels of mental retardation, some of whom also lived at Pennhurst. Intake information stated that her father was described as abusive and neglectful and her mother was described as "feeble-minded" with many of the maternal relations "mentally defective." Liz lived in boarding homes and attended school before being admitted to Pennhurst at the age of 8 in 1932. She lived there until 1978 when she was discharged to live in the community with her long time friend from Pennhurst. Once in the community, Liz developed the skills necessary to live and work independently. She has no family contacts.

Past Medical History:
Taken from Pennhurst discharge information that described her health as good through all her years at Pennhurst with no serious illnesses or injuries, and from CLA medical records.

Vision: 5/90- Early cataracts both eyes; 6/91- The Eye institute- Compound hyperopic astigmatism with presbyopia; no signs of diabetic retinopathy; Has annual eye exams; 7/92-CHA with presbyopia O. U., mild cortical spoking O.U., retinal pigmentary degeneration;

Hearing: 6/90- Osteopathic Med. Ctr. Audiology- Normal hearing; Has annual screenings by
Primary Care Physician and hearing is described as normal;

Respiratory System: '86- normal chest x-ray; No history of chronic or recurring respiratory problems; has occasional bouts of hoarseness;

Cardiovascular system: Liz states she had scarlet fever while a child but there is no documentation in available records; Long history of high blood pressure, Liz states she took blood pressure medication while at Pennhurst; 11/89 Abnormal EKG followed by ischemic work-up that revealed a positive stress thallium revealing global myocardial ischemia; Elevated cholesterol; 1/90- Cardiovascular consultation with Dr. Arnold- Ischemic heart disease with silent ischemia and positive stress thallium test; hypertensive cardiovascular disease, controlled; Normal sinus rhythm; Mild carotid artery narrowing; 3/90 Cardiac catheterization- severe triple vessel disease with significant diffuse distal disease and evidence of an old anterioapical MI; 4/91- AV Doppler studies revealed normal arterial and venous studies of the lower extremities; Sees cardiologist quarterly and responds to medical management; 1/94 hospitalized at Hahnemann for episode of congestive failure; cardiac catheterization, discharged with recommendations to continue to manage cardiac status medically;

Digestive System: 4/87- Double contrast barium enema- stool hemoccult positive- results- negative;

Musculoskeletal System: Long history of osteoarthritis with joint pain reported by Liz in shoulders, elbows, hips, ankles and knees; 4/87- Ba enema notes- Scoliosis of the lumbar spine with convexity to the left, most prominent at the L2 level. Degenerative changes of the lumbar spine are present;

Nervous System: Mild mental retardation; No history of trauma or seizures

Genito-urinary System: 6/85- negative mammogram; 11/93- Normal PAP, has annual Gyn evaluations with no abnormalities noted; 8/93- No evidence of suspicious lesions;

Endocrine System: Long history of being overweight; '87- Diabetes- maintained on oral hypoglycemics, avoids sugar and eats well-balanced meals, treated by primary physician and endocrinologist; Sugars run, when high, in low to mid 200's.

Integumentary System: (skin, nails, hair) ongoing routine podiatric care for diabetic foot care, mycotic nails, painful ingrown nails, both feet, and recurring athlete’s foot;

Lymphatic System: 5/89- Mammogram notes 3 small lymph nodes; occasional episodes of edema in feet and legs;

Psychiatric / Behavioral: No history of psychiatric illness while at Pennhurst; Received no antipsychotic medications while at Pennhurst; 3/84 at the age of 60, became severely depressed, manifested by crying, statements of feeling "sad"; treated with Elavil 30 mg., daily, at bedtime, with some improvement; 10/86-Elavil discontinued, no apparent ill effects; Liz is independent and is capable of close personal relationships;

Dental: Multiple missing teeth, partial upper and lower dentures of 11 teeth each; maintains good oral hygiene;
Immunizations:
Hepatitis status: 2/87- Hepatitis screen- exposed to Hepatitis A and B in past, no active
disease now, has developed immunity through exposure, no immunization necessary;
TB status: 8/92- Negative
Tetanus: 2/84 Diphtheria: 2/84

Allergies / Sensitivities: Perfumes and scented soaps

Current Health Status:
Mild mental retardation
Severe triple coronary artery disease
Cardiomyopathy
Mitral valve disease
Hypertension
Hyperlipidemia
Osteoarthritis
Diabetes Mellitus Type II
Scoliosis of lumbar spine
Degenerative changes of lumbar spine

Current Medications:
Nitrobid 6.5 mg, bid
Lanoxin 0.125 mg daily
Ecotrin 25 mg, tid, with meals
Lasix 40 mg, daily
Feldene 20 mg, daily
K-Dur 20 meq, tid
Micronase 5 mg., tab. 2, bid 1/2 hr. before meals
Vasotec 10 mg., bid

Angina
Heart disease
Osteoarthritis
Hypertension
Osteoarthritis
Potassium
Diabetes
Hypertension

Medical History Summary submitted by:

__________________________________  __________ Date
MEDICAL HISTORY SUMMARY

The Medical History Summary provides a comprehensive historical overview of the person. Documentation of past medical/dental information, psycho/social well being and functional abilities are integral parts of the document. This summary should be constructed from past and present documentation by a trained medical professional, such as a nurse, a nurse practitioner or a physician.

The Medical History Summary should be updated inclusively by an agency designee and approved by the physician at the time of the annual physical. The Medical History Summary should be revised and brought up to date every three to five years by a medical professional. Revisions and updates will become easier as this new system with its functional forms is implemented.

The Medical History Summary will provide the basis for the construction of the Personal Conditions Log, which delineates the chronic and acute medical, dental, psychological and behavioral conditions with which the person must cope throughout life. The Medical History Summary is a confidential document and intended to be read only by those who need access to information in order to provide medical care to an individual. It is not intended to be included in the annual support plans.

The summary should include the following sections:

1. Overview
   a. Basic identifying information
   b. Level of mental retardation
   c. Functional status, vision, hearing, expressive and receptive language skills, gross and fine motor skills
   d. Chronic medical conditions
   e. Need for adaptive equipment
   f. Ability to participate in personal care
   g. Type of living arrangement and amount of supervision

2. Developmental History
   a. Gestation, birth and delivery information
   b. Etiology of disability
   c. Developmental milestones
   d. Childhood diseases

3. Family/Social Information
4. Past medical history, organized chronologically by body system
   a. Eye, Ear, Nose, Throat
   b. Respiratory
   c. Cardiovascular
   d. Digestive
   e. Genitourinary
   f. Neurologic
   g. Musculoskeletal
   h. Endocrine
   i. Lymphatic

\[\text{c. PMHCC/REV. 6/93}\]
j. Skin, Hair, Nails

5. Psychiatric/Behavioral History
a. Past psychiatric diagnoses
b. Synopsis of medication usage, positive and negative reactions
c. Behaviors that interfere with health and safety
d. Past therapeutic interventions and results

6. Dental History

7. Immunizations (must include)
a. Hepatitis status
b. TB status
c. Tetanus

8. Allergies/Sensitivities

9. Current Health Status

10. Current Medications

The Medical History Summary should be a brief synopsis, not more than three pages, which will quickly and clearly provide a comprehensive description of the person.

Notes: