

**Self-Reported Medical Information Form
(to be completed by the applicant)**

NAME: _____ **Date:** _____

Please provide answers to the following questions and add comments where ever possible:

Do you use mobility aids?			Additional Comments
	Wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes (please circle): Electric Manual	
	Scooter? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes (please circle): Indoor? Outdoor?	
	Walker? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes (please circle): 2 wheeled? 4 wheeled?	
	Cane? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes (please circle): Single? Quad?	
Can you manage stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Can you walk a city block?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Can you administer your own medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Can you dress yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Can you maintain your own daily personal hygiene?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who assists you?	
Have you had any falls in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

About your physical health:		Additional Comments
Allergies to food?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes what foods:
Allergies to medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes what medications:
Allergies to anything in the environment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes what items:
Hearing problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes do you wear a hearing aid? <input type="checkbox"/> Yes

This personal information is being collected under the authority of the Alberta Housing Act and Alberta Regulation 244/94 (Social Housing Accommodation Regulation) and will be used to evaluate the need and eligibility for subsidized senior citizen housing. It is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act.

		<input type="checkbox"/> No
Vision problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Urine incontinence problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes how do you manage this?
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes how is it controlled?

Habits		Additional Comments
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If you have quit how long has it been?
Do you use oxygen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Can you administer you own medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you receive any other support services? (Home Care, Social Worker, Meals on Wheels, Life Line, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Mental Health		Additional Comments
How would you describe your mood over the last 3 months?	<input type="checkbox"/> Happy <input type="checkbox"/> Upbeat and positive <input type="checkbox"/> Unhappy and down <input type="checkbox"/> Sad <input type="checkbox"/> Lonely <input type="checkbox"/> Shy <input type="checkbox"/> Frustrated/Angry	How do you manage this condition (medication, support services)?
Have you been diagnose with any of the following?	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Paranoia <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Addiction to alcohol <input type="checkbox"/> Addiction to drugs <input type="checkbox"/> Attempted suicide	How do you manage this condition (medication, support services)?
Do you have any memory loss?	<input type="checkbox"/> Yes	

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	<input type="checkbox"/> No	
Do you have any difficulties with hoarding/collecting items?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Over the last 3 months has your emotion or physical health restricted your daily social activities with family, friends and or group settings?	<input type="checkbox"/> No <input type="checkbox"/> Occasionally <input type="checkbox"/> Often	
Have you had any injury or serious illness within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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