

Personal Health Record & Contact Information

Personal Information

Name _____

Date of birth _____

Address _____

Home phone _____

Cell phone _____

Email _____

Alternate address _____

Alternate phone _____

Emergency Contact Information

Name _____

Relationship _____

Home phone _____

Cell phone _____

Insurance Information

Primary insurance _____

Identification/group number _____

Supplemental insurance _____

Secondary insurance _____

Medical Information

Physical Examination Date of last physical _____

Allergies List all food and/or drug allergies _____

Medical Conditions List all current conditions for which you are being treated and any new symptoms you wish to discuss _____

Medication & Dosages Include any over-the-counter medications, vitamins, and supplements _____

Surgeries List most recent surgeries first _____

Hospitalizations List most recent hospitalizations first _____

Treatments List any current/ongoing treatments (cardiac rehab, physical therapy, etc.) _____

Testing List any recent testing (MRI, CT Scan, etc.) and dates _____

Immunizations **Type** **Date** _____

Medical Information (continued)

Implants	Implanted medical devices (pacemaker, knee joint, etc.)

Dental	Dental or oral health issues

Vision	Medical treatment for vision problems

Hearing	Hearing issues (use of hearing devices or other auditory problems)

Lifestyle Information

<input type="checkbox"/> Alcohol	Drink(s) per week	Number of years
<input type="checkbox"/> Smoking	Pack(s) per day	Number of years
<input type="checkbox"/> Exercise	Type(s)	Days per week
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

Legal Documents / Medical Directives

<input type="checkbox"/> Living Will	_____
<input type="checkbox"/> Durable Power of Attorney for Healthcare	_____
<input type="checkbox"/> Power of Attorney	_____
<input type="checkbox"/> Other	_____
<input type="checkbox"/> Other	_____

Document(s) location _____	
Executor's Name _____	
Phone _____	Fax _____
Email _____	

Family Medical History

Check all items that apply to your family members' present state of health or any illnesses they have had:

	Mother	Father	Siblings	Grandparent	Children
Enter ages of relatives					
If deceased, indicate age and cause of death					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart condition					
Hemodialysis					
Hepatitis					
High blood cholesterol					
High blood pressure					
Kidney disease					
Liver disease					
Mental retardation					
Rheumatic fever					
Seizures					
Smoking					
Stomach / intestinal problems					
Stroke					
Thyroid disorders					
Tuberculosis					
Tumor					

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