

Health Information Form *for Adults*



A. IDENTIFICATION

Name (Last)		(First)	(Middle)
Maiden Name			
Primary Address			
City	State	Zip Code	Country
Alternate Address			
City	State	Zip Code	Country
Home Phone	Work Phone		
Cell Phone	E-mail Address		
Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Height	Weight	Eye Color	Hair Color
Ethnicity/Race	Birthmarks/Scars		
Blood / RH Type	Special Conditions	Marital Status	
Occupation			
Company Name			
Address			
City	State	Zip Code	Country
Phone Number	Languages Spoken—Primary and Secondary		
Primary Health Insurance Carrier	Policy Number		
Secondary Health Insurance Carrier	Policy Number		

B. EMERGENCY CONTACTS

In Case of Emergency, Notify: Primary Contact

Name (Last)		(First)	(Middle)
Relationship			
Address			
City	State	Zip Code	Country
Home Phone	Work Phone		
Cell Phone	E-mail Address		

In Case of Emergency, Notify: Secondary Contact

Name (Last)		(First)	(Middle)
Relationship			
Address			
City	State	Zip Code	Country
Home Phone	Work Phone		
Cell Phone	E-mail Address		

In Case of Emergency, Notify: Medical Contact

Physician (Indicate Specialty)	
Phone	
Dentist	Phone
Pharmacy	Phone

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C. HEALTHCARE PROVIDERS

Healthcare Provider Speciality		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		
E-mail Address					
Fax					
Web Address/URL					

Healthcare Provider Speciality		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		
E-mail Address					
Fax					
Web Address/URL					

Healthcare Provider Speciality		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		
E-mail Address					
Fax					
Web Address/URL					

Healthcare Provider Speciality		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		
E-mail Address					
Fax					
Web Address/URL					

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D. INSURANCE PROVIDERS

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/URL			
Address				Primary Insured Person—Name			Social Security No.
City		State	Zip Code	Country		Employer Name	
Contact—Name		Phone		Address			
Identification—Group Number		Member (ID) Number		City	State	Zip Code	Country
Contact Information—Phone			Emergency Phone No. (after hours)				
				Phone Number			

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/URL			
Address				Primary Insured Person—Name			Social Security No.
City		State	Zip Code	Country		Employer Name	
Contact—Name		Phone		Address			
Identification—Group Number		Member (ID) Number		City	State	Zip Code	Country
Contact Information—Phone			Emergency Phone No. (after hours)				
				Phone Number			

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/URL			
Address				Primary Insured Person—Name			Social Security No.
City		State	Zip Code	Country		Employer Name	
Contact—Name		Phone		Address			
Identification—Group Number		Member (ID) Number		City	State	Zip Code	Country
Contact Information—Phone			Emergency Phone No. (after hours)				
				Phone Number			

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E. LEGAL DOCUMENTS/MEDICAL DIRECTIVES

<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare			
<input type="checkbox"/> Power of Attorney			
Document Location (Physical Location)			
Location Name (for example, Bank of America)			
Address			
City	State	Zip Code	Country
Legal Representative (Name of person who you have assigned legal authority)			
Address			
City	State	Zip Code	Country
Contact Information			
Home Phone		Cell Phone	
Pager		E-mail Address	
Work Phone		Work E-mail Address	
Fax			
Date Filed			
Organ Donor		State Where Registered	
<input type="checkbox"/> Yes <input type="checkbox"/> No			

Fax			
Contact (Name of person who has access to the document)			
Address			
City	State	Zip Code	Country
Contact Information			
Home Phone		Cell Phone	
Pager		E-mail Address	
Work Phone		Work E-mail Address	
Fax			
Date Filed			
Organ Donor		State Where Registered	
<input type="checkbox"/> Yes <input type="checkbox"/> No			

<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare			
<input type="checkbox"/> Power of Attorney			
Document Location (Physical Location)			
Location Name (for example, Bank of America)			
Address			
City	State	Zip Code	Country
Legal Representative (Name of person who you have assigned legal authority)			
Address			
City	State	Zip Code	Country
Contact Information			
Home Phone		Cell Phone	
Pager		E-mail Address	
Work E-mail Address		Work Phone	

Fax			
Contact (Name of person who has access to the document)			
Address			
City	State	Zip Code	Country
Contact Information			
Home Phone		Cell Phone	
Pager		E-mail Address	
Work Phone		Work E-mail Address	
Fax			
Date Filed			
Organ Donor		State Where Registered	
<input type="checkbox"/> Yes <input type="checkbox"/> No			

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F. MEDICAL HISTORY check appropriate

	Date of Onset		Date of Onset
<input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Hypoglycemia	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Chlamydia		<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Pain or Pressure in Chest	
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Palpitations	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Periods of Unconsciousness	
<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Eye Problem		<input type="checkbox"/> Rheumatism	
<input type="checkbox"/> Fainting		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Frequent or Severe Headache		<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Stomach, Liver, or Intestinal Problems	
<input type="checkbox"/> Gonorrhea		<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Hearing Impairment		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Heart Condition		<input type="checkbox"/> Tumor	
<input type="checkbox"/> Hemodialysis		<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Herpes		<input type="checkbox"/> Urinary Tract Infection	
<input type="checkbox"/> High Blood Cholesterol		<input type="checkbox"/> Other	

G. INFECTIOUS DISEASES

Disease	Age	Date	Remarks
Chicken Pox			
Hepatitis			
Measles			
Mumps			
Pertussis / Whooping Cough			
Pneumonia			
Polio			
Rubella			
Scarlet Fever			
Other			

H. IMMUNIZATIONS

Immunization for	Age	Date	BOOSTER 1		BOOSTER 2		BOOSTER 3	
			Age	Date	Age	Date	Age	Date
Diphtheria								
Hepatitis B								
Measles								
Mumps								
Pertussis/Whooping Cough								
Polio								
Rubella								
Smallpox								
Tetanus								
Tuberculosis								
Typhoid								
Other								

I. ALLERGIES/DRUG SENSITIVITIES

Allergy/Sensitivity Type (include medications, foods, environmental, or other)	Reaction	Date Last Occurred	Treatment

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J. FAMILY MEMBER HISTORY

	Mother	Father	Sibling(s)	Grandparent(s)	Children
Enter ages of relatives					
If deceased, indicate age and cause of death					
Check all items that apply for their present state of health or any illnesses they have had.					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
Hemodialysis					
Hepatitis					
High Blood Cholesterol					
High Blood Pressure					
Kidney Disease					
Mental Retardation					
Rheumatic Fever					
Seizures					
Smoking					
Stomach, Liver, or Intestinal Problems					
Stroke					
Thyroid Disorders					
Tuberculosis					
Tumor					
Other					

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K. LIFESTYLE

<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) of Exercise	Days Per Week

L. HEALTH LOG

Noninfectious major illnesses. Include pregnancies and childbirth.

Date Diagnosed	Doctor	Nature of Health Problem	Age at Onset	Condition Status	Remarks <small>(Such as, medications, special tests, x-rays, length of hospital stay, surgery, and so on)</small>



MEDICATIONS (Prescription/Non-Prescription) Update Regularly

Note: Include all prescription medications, (such as nitroglycerin) over-the-counter medications (taken on a regular basis), vitamin supplements, and herbal remedies.

N. DOCTOR VISITS

Date	Doctor	Reason	Diagnosis

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O. HOSPITALIZATIONS

Hospitalization Type (includes emergency room visits)	Diagnosis		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 2px;">Admission Date</td> <td style="width: 75%; padding: 2px;">Discharge Date</td> </tr> </table>	Admission Date	Discharge Date	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Admission Date	Discharge Date		
Doctor	Complications		
Hospital	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
Reason	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		

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Hospital	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
Reason	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		

Hospitalization Type (includes emergency room visits)	Diagnosis		
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Hospital	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
Reason	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		

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P. SURGERIES

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

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Q. LAB OR IMAGING (Examples: X-ray, MRI, Mammogram)

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

R. MEDICAL DEVICES (Examples: pacemaker, insulin pumps, breathing devices)

Device Type	Doctor	Device Type	Doctor
Hospital	Date	Hospital	Date
Reason		Reason	

T. VISION

Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	
Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	
Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	

U. DENTAL

Date of Visit	Dentist	Problems	Resolution