

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 (<i>Indicate Specialty</i>)	
Phone	
Dentist	Phone
Pharmacy	Phone

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C. HEALTHCARE PROVIDERS

Healthcare Provider Type		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 Type		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 Type		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 Type		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

<p><input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare</p> <p><input type="checkbox"/> Power of Attorney</p> <p>Document Location (Physical Location)</p> <hr/> <p>Location Name (for example, Bank of America)</p> <hr/> <p>Address</p> <hr/> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">City</td> <td style="width: 10%;">State</td> <td style="width: 15%;">Zip Code</td> <td style="width: 50%;">Country</td> </tr> </table> <p>Legal Representative (Name of person who you have assigned legal authority)</p> <hr/> <p>Address</p> <hr/> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">City</td> <td style="width: 10%;">State</td> <td style="width: 15%;">Zip Code</td> <td style="width: 50%;">Country</td> </tr> </table> <p>Contact Information</p> <hr/> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Home Phone</td> <td style="width: 50%;">Cell Phone</td> </tr> <tr> <td>Pager</td> <td>E-mail Address</td> </tr> <tr> <td>Work E-mail Address</td> <td>Work Phone</td> </tr> </table>	City	State	Zip Code	Country	City	State	Zip Code	Country	Home Phone	Cell Phone	Pager	E-mail Address	Work E-mail Address	Work Phone	<p>Fax</p> <hr/> <p>Contact (Name of person who has access to the document)</p> <hr/> <p>Address</p> <hr/> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">City</td> <td style="width: 10%;">State</td> <td style="width: 15%;">Zip Code</td> <td style="width: 15%;">Country</td> </tr> </table> <p>Contact Information</p> <hr/> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Home Phone</td> <td style="width: 40%;">Cell Phone</td> </tr> <tr> <td>Pager</td> <td>E-mail Address</td> </tr> <tr> <td>Work Phone</td> <td>Work E-mail Address</td> </tr> </table> <p>Fax</p> <hr/> <p>Date Filed</p> <hr/> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Organ Donation Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 30%;">State Where Registered</td> </tr> </table>	City	State	Zip Code	Country	Home Phone	Cell Phone	Pager	E-mail Address	Work Phone	Work E-mail Address	Organ Donation Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No	State Where Registered
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F. MEDICAL HISTORY *check appropriate items*

	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			

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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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O. HOSPITALIZATIONS

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

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P. SURGERIES

Date	Doctor	Results
Hospital		
Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
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	

Health Information Form *for Children*



A. IDENTIFICATION

Name				<i>In Case of Emergency Notify:</i>	
Date of Birth		Sex: <input type="radio"/> Male <input type="radio"/> Female		Name	
Height	Weight	Eye Color	Blood/RH Type	Relationship	Phone
Mother's Name				Obstetrician	Phone
Address				Pediatrician	Phone
City	State	Zip	Other Physician (<i>Indicate Specialty</i>)		Phone
Home Phone		Work Phone		Pharmacy	Phone
Father's Name				Other	Phone
Address				Other	Phone
City	State	Zip	Other		Phone
Home Phone		Work Phone		Other	Phone
Languages Spoken				Other	Phone

B. BIRTH DATA

Hospital
Weight
Length
Physician
Perinatal Problems
Apgar Score

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F. INFECTIOUS DISEASES

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

G. 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								

