

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) | |
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| | |
| Phone | |
| Dentist | Phone |
| Pharmacy | Phone |

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C. HEALTHCARE PROVIDERS

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|--------------------------------|-------|--|---------|-------|-----------------------------------|
| 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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|--------------------------------|-------|--|---------|-------|-----------------------------------|
| 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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|--------------------------------|-------|--|---------|-------|-----------------------------------|
| 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

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|-----------------------------|--|--------------------|-----------------------------------|-----------------------------|--|---------------|---------------------|--------------|--|
| 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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|-----------------------------|--|--------------------|-----------------------------------|-----------------------------|--|---------------|---------------------|--------------|--|
| 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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|-----------------------------|--|--------------------|-----------------------------------|-----------------------------|--|---------------|---------------------|--------------|--|
| 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 <input type="checkbox"/> Yes | | | | State Where Registered | | | |
| <input type="checkbox"/> No | | | | | | | |

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|---|--|------------------------|----------|---------|--|
| 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 <input type="checkbox"/> Yes | | State Where Registered | | | |
| <input type="checkbox"/> No | | | | | |

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|---|--|-------|----------|---|--|--|--|
| <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 | | | |

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|---|--|------------------------|----------|---------|--|
| 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 <input type="checkbox"/> Yes | | State Where Registered | | | |
| <input type="checkbox"/> No | | | | | |

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 | | | |

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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 | | | | | |

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.

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O. HOSPITALIZATIONS

| | | |
|---|----------------|---------------|
| Hospitalization Type (includes emergency room visits) | | Diagnosis |
| Admission Date | Discharge Date | |
| Doctor | | |
| Hospital | | |
| Reason | | Complications |
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|---|----------------|---------------|
| Hospitalization Type (includes emergency room visits) | | Diagnosis |
| Admission Date | Discharge Date | |
| Doctor | | |
| Hospital | | |
| Reason | | Complications |
| | | |
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|---|----------------|---------------|
| 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 | | |
| Surgical Procedure | | |
| Description | | Comments |
| | | |
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| | | |
|--------------------|--------|----------|
| Date | Doctor | Results |
| Hospital | | |
| Surgical Procedure | | |
| Description | | Comments |
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|--------------------|--------|----------|
| Date | Doctor | Results |
| Hospital | | |
| Surgical Procedure | | |
| Description | | Comments |
| | | |
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|--------------------|--------|----------|
| 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 |
|---------------|---------|----------|------------|
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