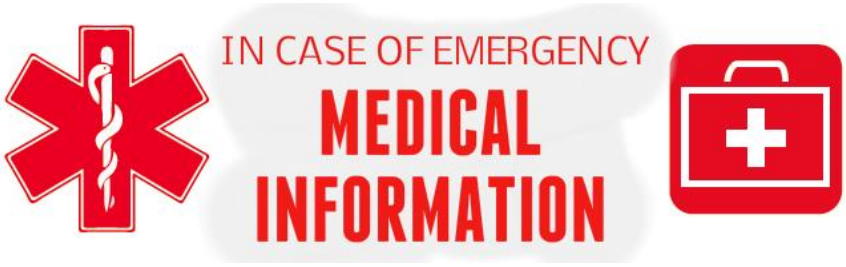

Date Updated _____

ABOUT ME			
First name		Last name	
Street address			
City state / province		Postal / zip code	
Primary phone		Cell phone	
Email		Gender	☐Male ☐Female ☐_____
Date of birth		Birthplace	
Primary language		Employed	☐Yes ☐No ☐Retired ☐Disabled
Occupation			
☐ I am hearing impaired ☐ I am sight impaired ☐ I have special needs ☐ Other			
Details			

MY EMERGENCY CONTACTS			
First name		Last name	
Street address			
City state / province		Postal / zip code	
Phone		Relationship	
First name		Last name	
Street address			
City state / province		Postal / zip code	
Phone		Relationship	

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MY DOCTORS			
Physician name		Specialty	
Street address			
City state / province		Postal / zip code	
Phone		Last seen	
Comments			
Physician name		Specialty	
Street address			
City state / province		Postal / zip code	
Phone		Last seen	
Comments			
Physician name		Specialty	
Street address			
City state / province		Postal / zip code	
Phone		Last seen	
Comments			
Physician name		Specialty	
Street address			
City state / province		Postal / zip code	
Phone		Last seen	
Comments			
Physician name		Specialty	
Street address			
City state / province		Postal / zip code	
Phone		Last seen	
Comments			

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MY DIRECTIVES	
I have signed an advance healthcare directive	☐Yes ☐No
Location of my advance healthcare directive	
I have a DNR (Do Not Resuscitate) directive	☐Yes ☐No
I have signed a Power of Attorney for Healthcare	☐Yes ☐No
Contact information for my POA	

MY ALLERGIES			
I'M ALLERGIC TO			
☐Iodine	☐X-Ray Contrast Dye	☐Latex/Rubber	☐Novocaine
☐Wasp Stings	☐Bee Stings	☐Adhesive Tape	☐Anesthesia
I carry an EpiPen	☐Yes ☐No	The EpiPen is for:	

MY FOOD AND ENVIRONMENTAL ALLERGIES	
TYPE	REACTION

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MY MEDICATIONS

MEDICATIONS I'M ALLERGIC TO	DESCRIBE ALLERGIC REACTION

MEDICATIONS I PREFER NOT TO TAKE DUE TO PRIOR UNPLEASANT SIDE EFFECTS			

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MEDICATIONS I AM CURRENTLY TAKING		
NAME OF MEDICATION	DOSE	HOW OFTEN TAKEN

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SUPPLEMENTS OR VITAMINS I AM CURRENTLY TAKING		
NAME OF SUPPLEMENT OR VITAMIN	DOSE	HOW OFTEN TAKEN

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MY HEALTH EXAMS

I HAVE TESTED POSITIVE FOR

☐Chicken Pox	☐Tuberculosis	☐HIV	☐Hepatitis	Type:	

I'VE HAD THESE OTHER TESTS

TEST	DATE	RESULTS
Chest X-ray		
Cholesterol		
Triglyceride		
Other lipid data		
Colonoscopy		
Mammogram		
Pap test		
Bone density test		
Prostate exam		

MY IMMUNIZATIONS

Pneumonia vaccine	Year:		BCG (to prevent TB)	Year:	
Diphtheria/Tetanus	Year:		Measles/Mumps/Rubella	Year:	
Hepatitis A (2 shot series)	Year:		Polio	Year:	
Hepatitis B (3 shot series)	Year:		Influenza ("flu")	Year:	
I have traveled recently or plan to travel in the immediate future				☐Yes ☐No	

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MY FAMILY MEDICAL HISTORY			
FAMILY MEMBER	LIVING (L) OR DECEASED (D)	AGE	MAJOR ILLNESSES / CAUSE OF DEATH
Mother	☐L ☐D		
Father	☐L ☐D		
Maternal Grandmother	☐L ☐D		
Maternal Grandfather	☐L ☐D		
Paternal Grandmother	☐L ☐D		
Paternal Grandmother	☐L ☐D		
Sister	☐L ☐D		
Sister	☐L ☐D		
Sister	☐L ☐D		
Brother	☐L ☐D		
Brother	☐L ☐D		
Brother	☐L ☐D		
Aunt	☐L ☐D		
Aunt	☐L ☐D		
Uncle	☐L ☐D		
Uncle	☐L ☐D		
Child	☐L ☐D		
Child	☐L ☐D		
Child	☐L ☐D		
Child	☐L ☐D		

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MY FAMILY MEMBERS HAVE HAD THE FOLLOWING CONDITIONS		
ILLNESS/CONDITION	**FAMILY MEMBER**	**DETAILS**
Cancer		
Heart disease		
Diabetes		
Stroke/TIA		
High blood pressure		
High cholesterol or triglycerides		
Liver disease		
Alcohol or drug abuse		
Anxiety, depression, or psychiatric illness		
Tuberculosis		
Anesthesia complications		
Genetic disorder		

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MY HEALTH ISSUES

ENDOCRINE/GLANDULAR			
Thyroid problems or goiter	☐Yes ☐No	Testosterone deficiency	☐Yes ☐No
Diabetes	☐Yes ☐No	Cushing's syndrome	☐Yes ☐No
Hyperthyroidism	☐Yes ☐No	Intestinal disease, malabsorption	☐Yes ☐No
Hyperparathyroidism	☐Yes ☐No	Gaucher's disease	☐Yes ☐No
More Info			

DERMATOLOGIC/SKIN			
Skin trouble or rash	☐Yes ☐No	Flushing	☐Yes ☐No
Change in hair or nails	☐Yes ☐No	More Info	

HEAD, EYE, EAR, NOSE, THROAT			
Headache or migraine	☐Yes ☐No	Glaucoma	☐Yes ☐No
Eye or vision problem	☐Yes ☐No	Ear or hearing problem	☐Yes ☐No
Lasik or another corrective eye surgery	☐Yes ☐No	Dental plate, bridgework, or false teeth	☐Yes ☐No
Other eye surgeries	☐Yes ☐No	Temporomandibular joint (TMJ) problems	☐Yes ☐No
Cataracts or surgery to correct cataracts	☐Yes ☐No	More Info	

RESPIRATORY/LUNGS			
Coughing	☐Yes ☐No	Snore	☐Yes ☐No
Wheezing or shortness of breath	☐Yes ☐No	Tuberculosis or pneumonia	☐Yes ☐No
More Info			

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CARDIOVASCULAR			
Chest pain or tightness	☐Yes ☐No	Hyperlipidemia (cholesterol, etc.)	☐Yes ☐No
Palpitations (skipped beats)	☐Yes ☐No	Heart attack, angina	☐Yes ☐No
Swollen legs or feet	☐Yes ☐No	Heart murmur	☐Yes ☐No
Hypertension (high blood pressure)	☐Yes ☐No	More Info	
ABDOMINAL/DIGESTIVE			
Abdominal pain	☐Yes ☐No	Jaundice	☐Yes ☐No
Bloating, gas, or indigestion	☐Yes ☐No	Liver disease	☐Yes ☐No
Heartburn	☐Yes ☐No	Gallbladder problems	☐Yes ☐No
Ulcer	☐Yes ☐No	Pancreatitis	☐Yes ☐No
Difficulty swallowing	☐Yes ☐No	Colon cancer or colon polyps	☐Yes ☐No
More Info			
URINARY			
Urinary problems (pain or frequency)	☐Yes ☐No	Kidney stones	☐Yes ☐No
Urinary infections	☐Yes ☐No	More Info	
BREASTS			
Breast cancer or a lump	☐Yes ☐No	Pain, tenderness, or discharge	☐Yes ☐No
More Info			

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MUSCULOSKELETAL			
Joint or muscle pains or stiffness that limit mobility	☐Yes ☐No	Fracture	☐Yes ☐No
Joint swelling, redness, or deformity	☐Yes ☐No	Implanted plates, prosthetic, pins or screws	☐Yes ☐No
Back pain	☐Yes ☐No	Osteoporosis	☐Yes ☐No
More Info			
NEUROLOGICAL			
Numbness or muscle weakness	☐Yes ☐No	Stroke	☐Yes ☐No
Loss of consciousness (black-out spells)	☐Yes ☐No	Panic attacks	☐Yes ☐No
Dizziness of lightheadedness	☐Yes ☐No	Epilepsy	☐Yes ☐No
Impaired memory or confusion	☐Yes ☐No	Seizures	☐Yes ☐No
Difficulty concentrating	☐Yes ☐No	Anxiety, depression, or mental illness	☐Yes ☐No
More Info			
FOR MEN			
Prostate problems	☐Yes ☐No	Pain or lump in scrotum or testicles	☐Yes ☐No
More Info			
FOR WOMEN			
Pregnant	☐Yes ☐No	Have had an abnormal pap smear	☐Yes ☐No
Still having menstrual periods	☐Yes ☐No	Taking medication for osteoporosis	☐Yes ☐No
More Info			

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MY ADDITIONAL MEDICAL HISTORY

		DETAILS
I have received a blood transfusion	☐Yes ☐No	
Anesthesia complications	☐Yes ☐No	
Blood problems (Abnormal bleeding, anemia, high or low white count)	☐Yes ☐No	
Cancer	☐Yes ☐No	
Treatment for alcohol and/or drug abuse	☐Yes ☐No	
Cosmetic or plastic surgery	☐Yes ☐No	

MY MAJOR ILLNESSES, INJURIES, OR SURGERIES

ILLNESS, INJURY, OR SURGERY	YEAR	DETAILS

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MY HOME ENVIRONMENT

I HAVE DIFFICULTY PERFORMING THESE ACTIVITIES		
☐Eating	☐Bathing	☐Dressing
☐Walking	☐Using Toilet	☐Housekeeping
My current living arrangement	☐House ☐Apartment ☐Nursing home ☐Other	
I live	☐Alone ☐With spouse ☐With family ☐With others	

THESE FAMILY OR FRIENDS ARE ABLE TO AID WITH MY HOMECARE NEEDS IF I WOULD EVER REQUIRE SUCH ASSISTANCE			
NAME	PHONE	NAME	PHONE

I HAVE THESE SPECIAL DIETARY NEEDS

MY LIFESTYLE

I have smoked cigarettes	☐Yes ☐No	I have smoked this many years	
I smoked this many packs per day		I quit smoking in the year	
I have used tobacco in other forms (pipe, cigars, chew)	☐Yes ☐No	I am exposed to “second-hand” smoke	☐Yes ☐No
I drink alcoholic beverages	☐Yes ☐No	I have this many drinks per day	
I, or others, are concerned about my drinking	☐Yes ☐No	I drink coffee or tea	☐Yes ☐No
I have used recreational/street drugs	☐Yes ☐No	I have lived outside the United States	☐Yes ☐No

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OTHER VITAL INFORMATION

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