Personal Health Record

A. IDENTIFICATION

Name (Last)	(First)	(Middle)	
Primary Address			
City	State	Zip Code	
Home Phone	Work Phone	Mobile Phone	
Date of Birth (M/D/YY)		Sex: Male Female	
Blood Type, if known		Languages Spoken	
Occupation (If Relevant)		Company Phone	
Company Name		Company Fax	
Company Address	City	State	Zip Code

B. EMERGENCY CONTACTS

In Case of Emergency, Notify (Primary)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	
In Case of Emergency, Notify (Secondary)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	
Specific Instruction:			

C. HEALTH INSURANCE/PROVIDER INFORMATION

Primary Health Insurance Provider Type: __Private __Medicare __Medicaid __Other		
Member (ID) Number:		
Company Name (if Private)	ID#:	Group Plan #:
Phone Number	Primary Insured (name, if different from part A of this form)	
Primary Insured's Employer (if relevant)	Employer Phone Number	
Secondary Health Insurance Provider Type: __Private __Medicare __Medicaid __Other		
Member (ID) Number:		
Company Name (if Private)	ID#:	Group Plan #:
Phone Number	Primary Insured (name, if different from part A of this form)	
Primary Care Physician:	Phone Number	
Other Physicians: (Name/Phone Number/Specialty)		

D. ADVANCE DIRECTIVES

(includes Health Care Proxy, Living Will and Power of Attorney)

HEALTH CARE PROXY (complete the information about the person named as the agent on your Health Care Proxy form)

Name	Phone	Mobile Phone	Work Phone	
Agent Address	City	State	Zip Code	
Agent Work Address	City	State	Zip Code	
Document Location (physical location, for ex. safe deposit box)				
Document Contact (person with access to document)		Phone Number		
LIVING WILL				
Document Location (physical location, for ex. safe deposit box)				
Document Contact (person with access to document)		Phone Number		

POWER OF ATTORNEY (complete the information about the person who has the Power of Attorney)			
Name	Phone	Mobile Phone	Work Phone
Address	City	State	Zip Code
Work Address	City	State	Zip Code
Document Location (physical location, for ex. safe deposit box)			
Document Contact (person with access to document)		Phone Number	

E. ALLERGIES/DRUG SENSITIVITY
(include medications, foods, environmental factors and/or other)

Allergen	Reaction	Last Occurrence	Treatment

F. YOUR HEALTH HISTORY
Check all items that apply to your present state of health and any previous illnesses.

Alcoholism	High Blood Pressure
Arthritis	Kidney Disease
Asthma	Mental Retardation
Cancer	Rheumatic Fever
Diabetes Type I Type II	Seizures
Emphysema	Stomach, Liver, or Intestinal problems
Glaucoma	Stroke
Heart Condition	Thyroid Disorders
Hemodialysis	Tuberculosis
Hepatitis Type: A B	Tumor
High Blood Cholesterol	Other

G. YOUR LIFESTYLE				
Alcohol	Yes	No	Drink(s) Per Week:	Number of Years:
Smoking	Yes	No	Pack(s) Per Day:	Number of Years:

H. YOUR HEALTH EVENT LOG
Please indicate any hospitalizations, surgeries, or other major health events, including Emergency Room visits.

Health Event	Date	Diagnosis	Facility	Outcome