

Your Family Member's 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 Contact)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	
In Case of Emergency, Notify (Secondary Contact)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	

C. Health Insurance Information

Primary Health Insurance Provider Type: Private Medicare Medicaid Other

Member (ID) Number: _____

Company Name (if Private) _____

Group Plan Number: _____

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) _____

Group Plan Number: _____

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) _____

Group Plan Number: _____

Phone Number _____

Primary Insured (name, if different from part A of this form) _____

Primary Insured's Employer (if relevant) _____

Employer Phone Number _____

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 family member's 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 Sensitivities

(include medications, foods, environmental factors and/or other)

Allergen	Reaction	Last Occurrence	Treatment

F. Your Family Member's Health History

Check all items that apply to your family member's present state of health and any previous illnesses.

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

G. Your Family Member's Lifestyle				
Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drink(s) Per Week:	Number of Years:
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pack(s) Per Day:	Number of Years:

H. Your Family Member's Health Event Log				
<i>Please indicate any hospitalizations, surgeries, or other major health events, including Emergency Room visits.</i>				
Health Event	Date	Diagnosis	Facility	Outcome