

HEALTH INFORMATION FORM FOR ADULTS

Allergic to: _____

IDENTIFICATION

<p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Date of Birth _____</p> <p>Home Phone _____ Work Phone _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Height _____ Weight _____</p> <p>Eye Color _____ Blood/RH Type _____</p> <p>Languages Spoken _____</p> <p>Primary Health Insurance Carrier _____ Policy Number _____</p> <p>Secondary Health Insurance Carrier _____ Policy Number _____</p>	<p>In Emergency Contact: _____</p> <p>Contact Name _____ Relationship _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone _____ Work Phone _____</p> <p>Physician _____ Specialty _____ Phone _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Dentist _____ Phone _____</p> <p>Pharmacy _____ Phone _____</p>
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MEDICAL HISTORY

Date	Mark Appropriate Items	
_____	<input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive	_____ <input type="checkbox"/> Low Blood Pressure
_____	<input type="checkbox"/> Arthritis	_____ <input type="checkbox"/> Mental Retardation
_____	<input type="checkbox"/> Asthma	_____ <input type="checkbox"/> Pain or Pressure in Chest
_____	<input type="checkbox"/> Cancer	_____ <input type="checkbox"/> Palpitations
_____	<input type="checkbox"/> Diabetes	_____ <input type="checkbox"/> Paralysis
_____	<input type="checkbox"/> Dizziness	_____ <input type="checkbox"/> Periods of Unconsciousness
_____	<input type="checkbox"/> Epilepsy	_____ <input type="checkbox"/> Rheumatic Fever
_____	<input type="checkbox"/> Eye Problem	_____ <input type="checkbox"/> Shortness of Breath
_____	<input type="checkbox"/> Frequent or Severe Headache	_____ <input type="checkbox"/> Smoking (Packs/Day: _____ Number of Years: _____)
_____	<input type="checkbox"/> Hearing Impairment	_____ <input type="checkbox"/> Stomach, Liver, or Intestinal Problems
_____	<input type="checkbox"/> Heart Condition	_____ <input type="checkbox"/> Thyroid Problems
_____	<input type="checkbox"/> High Blood Cholesterol	_____ <input type="checkbox"/> Tuberculosis
_____	<input type="checkbox"/> High Blood Pressure	_____ <input type="checkbox"/> Urinary Tract Infection
_____	<input type="checkbox"/> Jaundice	_____ <input type="checkbox"/> Sexually Transmitted Diseases
_____	<input type="checkbox"/> Kidney Disease	_____ <input type="checkbox"/> Chlamydia
	<input type="checkbox"/> Hemodialysis	_____ <input type="checkbox"/> Herpes
		_____ <input type="checkbox"/> Gonorrhea
		_____ <input type="checkbox"/> Syphilis
		Other: _____

MAJOR ILLNESSES (non-infectious) / OPERATIONS (Include Pregnancies & Childbirth)

Date	Description	Location of Service

FAMILY MEDICAL HISTORY

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Birthplace						
Occupation						
Alcoholism						
Allergies						
Blood/Circulation						
Depression						
Cancer						
Diabetes						
Digestive System						
Drug Sensitivities						
Eye Disorder						
Heart Disease						
Hearing Disorder						
Hypertension						
Kidney Stones						
Liver Disorder						
Musculoskeletal						
Reproductive System						
Respiratory System						
Stroke						
Urinary/Prostate						
Major Surgery						
Alzheimer's Disease						
Other						
Age/Cause of Death						

ADDITIONAL INFORMATION

Electrocardiogram/X-ray — Results/Dates
Foreign Travel — Location/Dates

Obstetrical History
Other Significant Information (Tuberculin test)

DEVICES AND PROSTHESES

Date	Item	Date	Item
	Pacemaker		Artificial Heart Valve
	Artificial Joint Implant (Which Joint(s))		
		Contact Lenses	
	Other		

EYE INFORMATION

(Prescription Glasses)

	Sphere	Cylinder	Axis	Prism	Base
Right Eye (OD)					
Left Eye (OS)					

Add: _____ Base Curve: _____

Other: _____

Name of Physician: _____ Phone _____

IMPORTANT HEALTHCARE DOCUMENTS

Document	Date Signed	Where Filed
Power of Attorney for Healthcare Proxy		
Advance Directive/Living Will		
Organ Donor Card		
Other		

MEDICATIONS — Update Regularly

Date Started	Current Prescriptions: Name/Dose/Frequency

INFECTIOUS DISEASES

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

IMMUNIZATIONS

When planning to travel outside the US, check with your physician to determine what immunizations are necessary

Date	Vaccine	Date	Vaccine
	Hepatitis B		Rubella
	Influenza		Smallpox
	Measles		Tuberculosis
	Mumps		Tetanus/Diphtheria
	Pneumonia		Typhoid
	Polio		Other