PERSONAL PROFILE

PERSONAL PROFILE			
Name		Email	
Mobile Phone		Home Phone	
Address			
Birthdate		Gender	-
Height (Ft-In)		Weight -lb	
Eye Color	-	Do you live alone? ☐ Yes ☐ No	
If No, ☐ Child ☐ Children ☐ Friend ☐ Grandparent(s)			
☐ Parent(s), ☐ Sibling, ☐ Spouse, ☐ Significant ☐ Other			
Profession			
Employed by		Telephone # of Manager	
Language Spoken	-	Other Language	
Understand English	☐ Yes ☐ No		
Marital Status	-		
Religion			
Notes			
Veteran	☐ Yes ☐ No	If Yes ID Number	
Notes			

Pet(s)	☐ Yes ☐ No	If Yes,	Name	
Breed		Color		
Microchip number		Veterinarian name		
Veterinarian Address				
Phone				
Person(s) who will care for pet (name, address)				

Notes about the Pet:

ALLERGIES AND MEDICATION REACTION(S)

Allergy (foods, medications, tape, latex)	Reaction (e.g. Anaphylaxis, Difficulty Breathing, Hives, Nausea, Rash, Vomiting, Other)	Treatment

PRE- EXISTING MEDICAL CONDITIONS

To assist in this analysis, you may find the *Personal and Medical History PDF Form* helpful. It is located in the Resource Section.

Pre-Existing Medical Conditions	Notes

MEDICAL IMPLANTS

This section is important for several reasons; one is to assist the hospital before an MRI is performed.

- ☐ Aneurysm Stent or Aneurysm Clip
- ☐ Artificial Limbs
- ☐ Artificial Heart Value
- ☐ Body Art/Tattoos, Body Piercing
- ☐ Coronary Stents (Drug Coated/Bare Metal, Unknown)
- ☐ Dental - Metal Crowns, Fillings, Implants
- ☐ Gastric Band
- ☐ Implanted Cardio Defibrillator (ICD)
- ☐ Implanted Devices/Pumps/Stimulator
- ☐ Joint Replacements (specify in notes)
- ☐ Lens Implants
- ☐ Metal Implants
- ☐ Middle Ear Prosthesis
- ☐ None
- ☐ Pacemaker,
- ☐ Penile Implant Pins/Rods/Screws
- ☐ Prosthetic Eye
- ☐ Renal or other Stents,
- ☐ Tracheotomy
- ☐ Other *(Please specify)*

NOTES *(for each implant add date, location, or other details)*

SURGICAL HISTORY

- ☐ Appendix
- ☐ Breast Biopsy
- ☐ Cataract
- ☐ Colon
- ☐ Gallbladder
- ☐ Heart - Angio/Stent
- ☐ Heart - Bypass
- ☐ Heart - Valve
- ☐ Hernia
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Surgery/Replacement
- ☐ Lasik Surgery
- ☐ Other *(Please specify)*
- ☐ Metal Implants
- ☐ Middle Ear Prosthesis
- ☐ Mohs - Basal Cell
- ☐ Mohs - Squamous Cell
- ☐ None
- ☐ Spine Surgery
- ☐ Thyroid Surgery
- ☐ Tonsils
- ☐ Vascular Surgery
- ☐ Wisdom Teeth

NOTES (for each surgery *add name of doctor, date, treatment location, or other details)*

PREFERRED HOSPITAL	
Preferred Hospital	**Notes**

BLOOD TYPE	-

DENTAL		
Dentures - Removable Upper	☐ Yes	☐ No
Denture - Removable Lower	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
NOTES:		

DIET
NOTES:

HEARING & SPEECH		
Hearing Aid(s)	☐ Yes	☐ No
Speech Impairment	☐ Yes	☐ No
NOTES:		

IMMUNIZATIONS AND VACCINES

☐ Chickenpox (Varicella)	☐ Meningococcal
☐ Hepatitis A	☐ NONE
☐ Hepatitis B	☐ Polio (IPV)Pneumococcal (PCV and PPSV)
☐ Hib	☐ Shingles (Herpes Zoster)
☐ Human Papillomavirus (HPV)	☐ Tetanus
☐ Influenza (Flu)	☐ Diphtheria
☐ Measles	☐ Pertussis (TD, Tdap)
☐ Mumps	☐ Other (Please specify) _____
☐ Rubella (MMR)	

NOTES (for each immunization/vaccine try to *add date, treatment location, or other details*

ORGAN DONOR

☐ **I DO NOT** wish to donate my organs or tissues.

☐ **I DO** wish to be an organ donor (if medically possible) for the following purposes:

☐ Transplant ☐ Therapy ☐ Research ☐ Education

VISION	
Glasses	☐ Yes ☐ No
Contact Lenses	☐ Yes ☐ No
Color Blind	☐ Yes ☐ No

SMOKING / TOBACCO USE

☐ Current ☐ Past ☐ Never

If Current or Past - Type _____

Amount/Frequency _____

Number of Years & When Stopped (is applicable) _____

ALCOHOL

☐ Current ☐ Past ☐ Never

If Current or Past - Type _____

Amount/Frequency _____

Number of Years & When Stopped (is applicable) _____

RECREATIONAL DRUG USE

☐ Current ☐ Past ☐ Never

If Current or Past – Type _____

Amount/Frequency _____

Number of Years & When Stopped (is applicable) _____

EMERGENCY CONTACTS & HEALTH CARE PROXY AGENT			
	(1)	(2)	(3)
First Name, Last Name			
Relationship	-	-	-
Priority	-	-	-
Mobile Phone			
Home Phone			
Office Phone			
Email Address			
Home Address			
Notes			

EMERGENCY CONTACTS & HEALTH CARE PROXY AGENT			
	(4)	(5)	(6)
First Name, Last Name			
Relationship	-	-	-
Priority	-	-	-
Mobile Phone			
Home Phone			

Office Phone			
Email Address			
Home Address			
Notes			

PRIMARY PHYSICIAN		
First Name, Last Name		
Specialty	-	-
Other Specialty		
Office Phone		
Office Fax		
Mobile Phone		
Website		
Hospital Affiliation		
Medical Practice Name		
Email Address		
Office Address		
In Network Status	☐ Yes ☐ No	
Electronic Protected Health Information Record Locator (if applicable)		
NOTES:		