

A. IDENTIFICATION					B. EMERGENCY CONTACTS			
Name (Last) (First) (Middle)		(Middle)	In Case of Emergency, Notify Name (Last)	: Primary Cont	act (Middle)			
Maiden Name					Name (Last)	(1 1131)	(iviidule)	
Primary Address					Relationship			
City		State	Zip Code	Country	Address			
Alternate Address				1	City	State Zip Code	Country	
City		State	Zip Code	Country	Home Phone	Work Phone		
Home Phone		Work P	hone	<u> </u>	Cell Phone	E-mail Address		
Cell Phone		E-mail /	Address			1		
Date of Birth		☐ Mal	e	☐ Female	In Case of Emergency, Notify Name (Last)	: Secondary Co	ntact (Middle)	
Height	Weight	Eye Col	or	Hair Color				
Ethnicity/Race		Birthma	arks/Scars		Relationship			
Blood/RH Type		Special	Conditions	Marital Status	Address			
Occupation					City	State Zip Code	Country	
Company Name					Home Phone	Work Phone		
Address					Cell Phone	E-mail Address		
City		State	Zip Code	Country	L. Com of European Notife	. M. 1: . 1 C 4	4	
Phone Number		Langua	ges Spoken—Pi	rimary and Secondary	In Case of Emergency, Notify Physician (Indicate Specialty)	: Meantai Com	acı	
Primary Health Insu	ırance Carrier		Policy No	umber				
Secondary Health Ir	nsurance Carrier	Polic	y Number					
					Phone			
					Dentist	Phone		
					Pharmacy	Phone		



Page	No.

Healthcare Provider Speciality		Primary C	are Physician	Phone	Emergency Phone No. (after hours)
		<u>□</u> Y			
Name				E-mail Address	ı
Group or Association				Fax	
Address				Web Address/URL	
City	State	Zip Code	Country		
			I	I	
lealthcare Provider Speciality		Primary C	are Physician Yes 🔲 No	Phone	Emergency Phone No. (after hours)
lame				E-mail Address	1
roup or Association				Fax	
Address				Web Address/URL	
City	State	Zip Code	Country		
	l e			ı	
Healthcare Provider Speciality		Primary C	are Physician 'es 🖵 No	Phone	Emergency Phone No. (after hours)
Jame				E-mail Address	
Group or Association				Fax	
Address				Web Address/URL	
City	State	Zip Code	Country		

Healthcare Provider Speciality	Primary Care Physi	cian Phone I No		Emergency Phone No. (after hours)
Name	1	E-mail Add	ress	1
Group or Association		Fax		
Address		Web Addres	ss/URL	
City	State Zip Code	Country		



Page No.	
	_

D. INSURANCE PROVIDERS

D. INSUKANCI	PRO	VIDER	C S					
Insurance Provider Type				E-mail Address		Fax		
Company Name				Web Address/URL				
Address				Primary Insured Person—Nam	e			Social Security No.
City	State	Zip Code	Country	Employer Name				
Contact—Name	Phone			Address				
Identification—Group Number	Member	(ID) Number	·	City	S	tate	Zip Code	Country
Contact Information—Phone		Emergency Ph	one No. (after hours)	Phone Number				
Insurance Provider Type				E-mail Address		Fax		
Company Name				Web Address/URL		<u> </u>		
Address				Primary Insured Person—Nam	ne			Social Security No.
City	State	Zip Code	Country	Employer Name				
Contact—Name	Phone			Address				
Identification—Group Number	mber Member (ID) Number			City	S	State	Zip Code	Country
Contact Information—Phone		Emergency Ph	none No. (after hours)	Phone Number				
Insurance Provider Type				E-mail Address		Fax		
Company Name				Web Address/URL		<u> </u>		
Address				Primary Insured Person—Name	e			Social Security No.
City	State	Zip Code	Country	Employer Name				l
Contact—Name	Phone			Address				
Identification—Group Number	Member	(ID) Number		City	S	tate	Zip Code	Country
Contact Information—Phone		Emergency Ph	one No. (after hours)	Phone Number				



Page	No.

E. LEGAL DOCUMENTS/MEDICAL DIRECTIVES

□ Living Will□ Durable Power of□ Power of Attorney	f Attorne	y for Healthc	are	Fax			
Document Location (Physical Location)				Contact (Name of person who has acc	ess to the docume	nt)	
				Address			
Location Name (for example, Bank of America))						
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			
Legal Representative (Name of person who you	have ass	l signed legal at	uthority)	Home Phone	Cell Ph	one	
Address				Pager	E-mail	Address	
City	State	Zip Code	Country	Work Phone	Work E	-mail Address	
Contact Information			<u> </u>	Fax	•		
Home Phone	Cell Ph	one		Date Filed			
Pager	E-mail	Address		Organ Donation Organ Donor Yes	State V	/here Register	ed
Work E-mail Address	Work F	hone		☐ No			
				ı -			
☐ Living Will ☐ Durable Power or	f Attorne	ey for Healtho	are	Fax			
Power of Attorney				Contact (Name of person who has acc	ess to the docume	nt)	
Document Location (Physical Location)							
Location Name (for example, Bank of America)			Address			
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			•
Legal Representative (Name of person who you	have as	l signed legal a	uthority)	Home Phone	Cell Ph	one	
Address				Pager	E-mail	Address	
City	State	Zip Code	Country	Work Phone	Work f	-mail Address	,
Contact Information	State	Zip Code	Country	Work Phone Fax	Work I	-mail Address	
	State Cell Pr		Country		Work I	-mail Address	
Contact Information	Cell Pr		Country	Fax		E-mail Address	



Pag	je No.

$F\:.\:\:M\:E\:D\:I\:C\:A\:L\:\:\:H\:I\:S\:T\:O\:R\:Y\:\:\:$ check appropriate

	Date of Onset		Date of Onset
Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive		☐ High Blood Pressure	
Arthritis		☐ Hypoglycemia	
Asthma		☐ Jaundice	
Bronchitis		☐ Kidney Disease	
Cancer		☐ Low Blood Pressure	
Chlamydia		Mental Retardation	
Diabetes		Pain or Pressure in Chest	
Dizziness		Palpitations	
Emphysema		Periods of Unconsciousness	
Epilepsy		☐ Rheumatic Fever	
Eye Problem		☐ Rheumatism	
Fainting		☐ Seizures	
Frequent or Severe Headache		☐ Shortness of Breath	
Glaucoma		Stomach, Liver, or Intestinal Problems	
Gonorrhea		Syphilis	
Hearing Impairment		☐ Tuberculosis	
Heart Condition		☐ Tumor	
Hemodialysis		☐ Thyroid Problems	
Herpes		☐ Urinary Tract Infection	
High Blood Cholesterol		☐ Other	

G. INFECTIOUS DISEASES

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



Page	No.

H.IMMUNIZAT	IONS		B00	STER 1	B 0 0	STER 2	B 0 0	STER 3
Immunization for	Age	Date	Age	Date	Age	Date	Age	Date
Diphtheria								
Hepatitis B								
Measles								
Mumps								
Pertussis/Whooping Cough								
Polio								
Pubella								
mallpox								
etanus								
uberculosis								
yphoid								
ther								

I. ALLERGIES/DRUG SENSITIVITIES

Allergy/Sensitivity Type (include medications, foods, environmental, or other)	Reaction	Date Last Occurred	Treatment



Page	No.	

J. FAMILY MEMBER HISTORY

J. FAMILY MEMBER HISTORY	Mother	Father	Sibling(s)	Grandparent(s)	Children
	otner		w.mg(3)	a. aapa. circ(3)	JWI 611
Enter ages of relatives					
Effect ages of relatives					
If deceased, indicate age and cause of death					
Check all items that apply for their present state of health					
or any illnesses they have had.					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
Hemodialysis					
Hepatitis					
High Blood Cholesterol					
High Blood Pressure					
Kidney Disease					
Mental Retardation					
Rheumatic Fever					
Seizures					
Smoking					
Stomach, Liver, or Intestinal Problems					
Stroke					
Thyroid Disorders					
Tuberculosis					
Tumor	+				
Other					



P	age	No.	

K. LIFESTYLE

	Drink(s) Per Week	Number of Years
☐ Alcohol		
	Pack(s) Per Day	Number of Years
□ Smoking		
	Type(s) of Exercise	Days Per Week
☐ Exercise		

L. HEALTH LOG

Noninfectious major illnesses. Include pregnancies and childbirth.

Date Diagnosed	Doctor	Nature of Health Problem	Age at Onset	Condition Status	Remarks (Such as, medications, special tests, x-rays, length of hospital stay, surgery, and so on)



Page No.	

 $M \; E \; D \; I \; C \; A \; T \; I \; O \; N \; S$ (Prescription/Non-Prescription) Update Regularly

Note: Include all prescription medications, (such as nitroglycerin) over-the-counter medications (taken on a regular basis), vitamin supplements, and herbal remedies.



Page	No.

N. DOCTOR VISITS

Date	Doctor	Reason	Diagnosis



Pa	ge	No.	

O. HOSPITALIZATIONS

Hospitalization Type (includes emergency	room visits)	Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications
Hospitalization Type (includes emergency	room visits)	Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications
Hospitalization Type (includes emergency	room visits)	Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications



Page	No.

P. SURGERIES

I. SORGERIES			i	
Doctor Doctor		Results		
Hospital				
Surgical Procedure				
Description		Comments		
Date	Doctor	Results		
Hospital				
Surgical Procedure				
Description		Comments		
Date	Doctor	Results		
Hospital				
Surgical Procedure				
Description		Comments		
Date	Doctor	Results		
Date Hospital	Doctor	Results		
	Doctor	Results		
Hospital	Doctor	Results		
Hospital Surgical Procedure	Doctor			



Page	No.	
		П

Q. LAB OR IMAG	ING (.	Examples: A-ray, I	viki, Maiiinograiii)		
Test Type		Date	Test Type		Date
Requesting Doctor	Administered	I by	Requesting Doctor	Administer	ed by
Reason			Reason		
Result			Result		
Test Type		Date	Test Type		Date
Requesting Doctor	Administered	l by	Requesting Doctor	Administer	ed by
Reason	•		Reason		
Result			Result		
R. MEDICAL DEV	ICES	(Examples: pacema	aker, insulin pumps, breath	ing devi	ces)
Device Type	Doctor		Device Type	Doctor	
Hospital		Date	Hospital		Date
					l
Reason			Reason		



Page	No.	
		1

S. PHYSICAL/OCCUPATIONAL THERAPY

Therapy Type	Start Date	Stop Date	Frequency	Therapist	



Page	No.

T. VISION

Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	
Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	
Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	

U. DENTAL

Date of Visit	Dentist	Problems	Resolution