Health Information Form *for Adults*

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A. IDENTIFICATION

Name (Last) (First) (Middle)

Maiden Name

Primary Address

City | State | Zip Code | Country

Alternate Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | E-mail Address

Date of Birth | ☐ Male | ☐ Female

Height | Weight | Eye Color | Hair Color

Ethnicity/Race | Birthmarks/Scars

Blood/RH Type | Special Conditions | Marital Status

Occupation

Company Name

Address

City | State | Zip Code | Country

Phone Number | Languages Spoken—Primary and Secondary

Primary Health Insurance Carrier | Policy Number

Secondary Health Insurance Carrier | Policy Number

B. EMERGENCY CONTACTS

In Case of Emergency, Notify: Primary Contact

Name (Last) (First) (Middle)

Relationship

Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | E-mail Address

In Case of Emergency, Notify: Secondary Contact

Name (Last) (First) (Middle)

Relationship

Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | E-mail Address

In Case of Emergency, Notify: Medical Contact

Physician (Indicate Specialty)

Phone

Dentist | Phone

Pharmacy | Phone

C. HEALTHCARE PROVIDERS

Healthcare Provider Speciality	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No. (after hours)
Name		E-mail Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

Healthcare Provider Speciality	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No. (after hours)
Name		E-mail Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

Healthcare Provider Speciality	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No. (after hours)
Name		E-mail Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

Healthcare Provider Speciality	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No. (after hours)
Name		E-mail Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

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D. INSURANCE PROVIDERS

Insurance Provider Type

Company Name

Address

City | State | Zip Code | Country

Contact—Name | Phone

Identification—Group Number | Member (ID) Number

Contact Information—Phone | Emergency Phone No. (after hours)

E-mail Address | Fax

Web Address/URL

Primary Insured Person—Name | Social Security No.

Employer Name

Address

City | State | Zip Code | Country

Phone Number

Insurance Provider Type

Company Name

Address

City | State | Zip Code | Country

Contact—Name | Phone

Identification—Group Number | Member (ID) Number

Contact Information—Phone | Emergency Phone No. (after hours)

E-mail Address | Fax

Web Address/URL

Primary Insured Person—Name | Social Security No.

Employer Name

Address

City | State | Zip Code | Country

Phone Number

Insurance Provider Type

Company Name

Address

City | State | Zip Code | Country

Contact—Name | Phone

Identification—Group Number | Member (ID) Number

Contact Information—Phone | Emergency Phone No. (after hours)

E-mail Address | Fax

Web Address/URL

Primary Insured Person—Name | Social Security No.

Employer Name

Address

City | State | Zip Code | Country

Phone Number

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E. LEGAL DOCUMENTS/MEDICAL DIRECTIVES

☐ Living Will ☐ Durable Power of Attorney for Healthcare
☐ Power of Attorney

Document Location (Physical Location)

Location Name (for example, Bank of America)

Address

City	State	Zip Code	Country

Legal Representative (Name of person who you have assigned legal authority)

Address

City	State	Zip Code	Country

Contact Information

Home Phone	Cell Phone
Pager	E-mail Address
Work E-mail Address	Work Phone

Fax

Contact (Name of person who has access to the document)

Address

City	State	Zip Code	Country

Contact Information

Home Phone	Cell Phone
Pager	E-mail Address
Work Phone	Work E-mail Address

Fax

Date Filed

Organ Donation	*State Where Registered*
Organ Donor ☐ Yes ☐ No	

☐ Living Will ☐ Durable Power of Attorney for Healthcare
☐ Power of Attorney

Document Location (Physical Location)

Location Name (for example, Bank of America)

Address

City	State	Zip Code	Country

Legal Representative (Name of person who you have assigned legal authority)

Address

City	State	Zip Code	Country

Contact Information

Home Phone	Cell Phone
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Work E-mail Address	Work Phone

Fax

Contact (Name of person who has access to the document)

Address

City	State	Zip Code	Country

Contact Information

Home Phone	Cell Phone
Pager	E-mail Address
Work Phone	Work E-mail Address

Fax

Date Filed

Organ Donation	State Where Registered
Organ Donor ☐ Yes ☐ No	

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F. MEDICAL HISTORY 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			

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H. IMMUNIZATIONS

Immunization for	Age	Date	BOOSTER 1 Age	BOOSTER 1 Date	BOOSTER 2 Age	BOOSTER 2 Date	BOOSTER 3 Age	BOOSTER 3 Date
Diphtheria								
Hepatitis B								
Measles								
Mumps								
Pertussis/Whooping Cough								
Polio								
Rubella								
Smallpox								
Tetanus								
Tuberculosis								
Typhoid								
Other								

I. ALLERGIES/DRUG SENSITIVITIES

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

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M. MEDICATIONS (Prescription/Nonprescription) Update Regularly

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

Current Prescriptions: Name/Dose/Frequency	Date Started	Quantity Number	Stop Date	Prescribed By	Prescription Date	Prescription Number	Allergic Reaction	Comments

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J. FAMILY MEMBER HISTORY

	Mother	Father	Sibling(s)	Grandparent(s)	Children
Enter 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					

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K. LIFESTYLE

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

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)

N. DOCTOR VISITS

Date	Doctor	Reason	Diagnosis

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P. SURGERIES

Date	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
Hospital		
Surgical Procedure		
Description		Comments

Q. LAB OR IMAGING (Examples: X-ray, MRI, Mammogram)

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

R. MEDICAL DEVICES (Examples: pacemaker, insulin pumps, breathing devices)

Device Type	Doctor	Device Type	Doctor
Hospital	Date	Hospital	Date
Reason		Reason	

S. PHYSICAL/OCCUPATIONAL THERAPY

Therapy Type	Start Date	Stop Date	Frequency	Therapist

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