

A. IDEN	TIFICAT	ION	I		B. EMERGE	NCY C	ON	TACT	S
Name (Last)		(First)		(Middle)	In Case of Emerger	псү, Notify:			
Maiden Name					Name (Last)		(First)	(Middle)
Primary Address					Relationship				
City		State	Zip Code	Country	Address				
Alternate Address					City		State	Zip Code	Country
City		State	Zip Code	Country	Home Phone		Work	Phone	
Home Phone		Work P	hone		Cell Phone		E-mai	l Address	
Cell Phone		E-mail	Address		In Case of Emerger	ncy, Notify:	Secon	ıdary Con	tact
Date of Birth		☐ Mal	e	☐ Female	Name (Last)	1, 31	(First	_	(Middle)
Height	Weight	Eye Col	or	Hair Color	Relationship				
Ethnicity/Race	I	Birthma	arks/Scars		Address				
Blood/RH Type		Special	Conditions	Marital Status	City		State	Zip Code	Country
Occupation					Home Phone		Work	Phone	
Company Name					Cell Phone		E-mai	l Address	
Address									
City		State	Zip Code	Country	In Case of Emerger	псү, Notify:	Medi	cal Conta	ct
Phone Number		Langua	ges Spoken—Pi	rimary and Secondary	Physician (Indicate Specialty))			
Primary Health Insu	rance Carrier	Polic	y Number						
Secondary Health Ir	surance Carrier	Polic	y Number						
					Phone				
					Dentist		Phone		
					Pharmacy		Phone		



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C. HEALTHCARE PROVIDERS

Healthcare Provider Type P			re Physician ∕es □ 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 Type		Primary Ca	re Physician	Phone	Emergency Phone No. (after hours)		
		١					
Name				E-mail Address			
Group or Association				Fax			
Address				Web Address/URL			
City	State	Zip Code	Country				
Healthcare Provider Type		Primary Ca	re 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 Type		Primary Ca	are 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		E-mail Address Fax					
Company Name				Web Address/URL			
Address		Primary Insured Person—Name			Social Security No.		
City	State	Zip Code	Country	Employer Name			
Contact—Name	Phone	-		Address			
Identification—Group Number	Member (ID) Number		City	State	Zip Code	Country
Contact Information—Phone	1	Emergency Pho	one No. (after hours)	Phone Number			I.
	•						
Insurance Provider Type				E-mail Address	Fax		
Company Name				Web Address/URL	<u> </u>		
Address				Primary Insured Person—Name			Social Security No.
City	State	Zip Code	Country	Employer Name			<u> </u>
Contact—Name	Phone			Address			
Identification—Group Number	Member ((ID) Number		City	State	Zip Code	Country
Contact Information—Phone		Emergency Pho	one No. (after hours)	Phone Number		ı	
Insurance Provider Type				E-mail Address	Fax		
Company Name				Web Address/URL			
Address				Primary Insured Person—Name			Social Security No.
City	State	Zip Code	Country	Employer Name			
Contact—Name	Phone	1	1	Address			
Identification—Group Number	Member (ID) Number		City	State	Zip Code	Country
Contact Information—Phone		Emergency Pho	one No. (after hours)	Phone Number	1	I	
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F	Page	No.	

E. LEGAL DOCUMENTS/MEDICAL DIRECTIVES

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 Work Phone Cell Phone Fax Date Filed Organ Donation Organ Donation Organ Donarion	☐ Living Will ☐ Durable Power o							
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Home Phone Cell Phone Cell	City	State	Zip Code	Country	Work Phone	Work E	E-mail Address	i
Pager	Contact Information	<u> </u>			Fax	•		
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Contact Information Fax Date Filed Organ Donation Organ Donor Yes State Where Registered	Address	State			- City - Contact Information		Zip Code	Country
Home Phone Cell Phone Pager E-mail Address Date Filed Organ Donation Organ Donor Yes State Where Registered	Address City Legal Representative (Name of person who you	State			City Contact Information Home Phone	Cell Pł	Zip Code	Country
Pager E-mail Address Organ Donation Organ Donor Yes The New York Property of the Property	Address City Legal Representative (Name of person who you Address	State I have ass	igned legal a	uthority)	City Contact Information Home Phone Pager	Cell Ph E-mail	Zip Code	
Organ Donor	Address City Legal Representative (Name of person who you Address City	State I have ass	igned legal a	uthority)	City Contact Information Home Phone Pager Work Phone	Cell Ph E-mail	Zip Code	
Work E-mail Address Work Phone	Address City Legal Representative (Name of person who you Address City Contact Information	State have ass	igned legal a	uthority)	City Contact Information Home Phone Pager Work Phone Fax	Cell Ph E-mail	Zip Code	
	Address City Legal Representative (Name of person who you Address City Contact Information Home Phone	State J have ass State Cell Ph	zip Code	uthority)	City Contact Information Home Phone Pager Work Phone Fax Date Filed Organ Donation	Cell Ph E-mail Work	Zip Code none Address E-mail Address	



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F. MEDICAL HISTORY check appropriate items

	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

BOOSTER 1 BOOSTER 2 BOOSTER 3

			В00	STER 1	BOOSTER 2		BOOSTER 3	
Immunization for	Age	Date	Age	Date	Age	Date	Age	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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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)

Health Information Form for Adults

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American Health Information
Management Association®

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M . $M \ E \ D \ I \ C \ A \ T \ I \ O \ N \ S$ (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	Q uantity Number	Stop Date	Prescribed By	Prescription Date	Prescription Number	Allergic Reaction	Comments



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N. DOCTOR VISITS

Date	Doctor	Reason	Diagnosis

$\textbf{Health Information Form} \ \textit{for Adults}$



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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

Health Information Form for Adults



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P. SURGERIES

Date	Doctor	Results	
Hospital			
Procedure			
Description		Comments	
Date	Doctor	Results	
Hospital			
Procedure			
Description		Comments	
Date	Doctor	Results	
Hospital			
Procedure			
Description		Comments	
Date	Doctor	Results	
Hospital			
Procedure			
Description		Comments	



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Test Type	Date	2	Test Type		Date
Requesting Doctor	Administered by		Requesting Doctor	Administer	red by
Reason			Reason		
Result			Result		
Test Type	Date	2	Test Type		Date
Requesting Doctor	Administered by		Requesting Doctor	Administer	red by
Reason			Reason	l	
Result			Result		
	I	xamples: p	acemaker, insulin pumps,	Ī	
Device Type	Doctor		Device Type	Doctor	
Hospital		Date	Hospital		Date
Reason			Reason		



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S. PHYSICAL/OCCUPATIONAL THERAPY

Therapy Type	Start Date	Stop Date	Frequency	Therapist

$\textbf{Health Information Form} \ \textit{for Adults}$



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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