



"The electronic link to your medical records"

## Personal Health Information

Today's Date:

### ABOUT ME

<b>Name</b>	<b>Gender</b>
<b>Date of Birth</b>	<b>Blood Type</b>
<b>Street Address/PO Box</b>	<b>Organ Donor</b>
<b>City</b>	<b>Living Will</b>
<b>State</b>	<b>Dentures</b>
<b>Zip</b>	<b>Smoker</b>
<b>Soc. Sec.#</b>	<b>Eye Wear/Contact</b>
<b>Height</b>	<b>Occupation</b>
<b>Weight</b>	<b>Business Phone</b>
<b>Ethnicity</b>	<b>E-mail</b>
<b>Religion</b>	<b>PCP</b>
<b>Home Phone</b>	<b>PCP Phone #</b>

### CONTACTS

#### Emergency Contacts

<b>Name</b>	<b>Relationship</b>	<b>Home Phone</b>	<b>Cell or Business</b>

#### Healthcare Contacts

<b>Name</b>	<b>Specialty</b>	<b>Business Phone</b>	<b>Cell Phone</b>

### INSURANCE

#### Primary Medical Insurance

**Primary Insurance Co.**  
**Phone #**  
**Primary Subscriber Name**  
**Group ID**  
**Member ID**

#### Secondary Medical Insurance

**Secondary Insurance Co.**  
**Phone #**  
**Secondary Subscriber Name**  
**Group ID**  
**Member ID**

#### Prescription Insurance

**Insurance Company**  
**Phone #**  
**Primary Subscriber Name**  
**Group ID**  
**Member ID**

#### Dental Insurance

**Insurance Company**  
**Phone #**  
**Primary Subscriber Name**  
**Group ID**  
**Member ID**

**PHYSICIAN(S)**

Full Name	Specialty	Day Phone	Business / Cell
-----------	-----------	-----------	-----------------

**IMPLANT DEVICE ID / MANUFACTURER / MODEL NUMBER, ETC.,**

**PREFERED HOSPITAL**

**PREFERED PHARMACY**

**DIABETIC**  Yes  No

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Type I – Insulin dependent  | <input type="checkbox"/> Type I – Non-Insulin dependent  | <input type="checkbox"/> Type I – Medication  | <input type="checkbox"/> Type I – Diet  |
| <input type="checkbox"/> Type II – Insulin dependent | <input type="checkbox"/> Type II – Non-Insulin dependent | <input type="checkbox"/> Type II – Medication | <input type="checkbox"/> Type II – Diet |

**CHOLESTEROL**

<b>Total Cholesterol:</b> <200 mg/dl	<b>Date Collected:</b>	<b>Blood Lab:</b>
--------------------------------------	------------------------	-------------------

<b>HDL:</b> <40 mg/dl	<b>LDL:</b> <130 mg/dl	<b>Triglycerides:</b> <150 mg/dl
-----------------------	------------------------	----------------------------------

**MEDICAL CONDITIONS**

**OTHER MEDICAL CONDITONS**

Condition	Details	Condition	Details
-----------	---------	-----------	---------

**MEDICAL HISTORY**

<u>Procedures and Surgeries</u>	Date of Procedure	Details
---------------------------------	-------------------	---------

**MENTAL HEALTH**

- Is stress a major problem for you?  Yes  No
- Do you feel depressed?  Yes  No
- Do you panic when stressed?  Yes  No
- Do you have problems with eating or your appetite?  Yes  No
- Do you cry frequently?  Yes  No
- Have you ever attempted suicide?  Yes  No
- Have you ever seriously thought about hurting yourself?  Yes  No
- Do you have trouble sleeping?  Yes  No
- Have you ever been to a counselor?  Yes  No

**IMMUNIZATIONS – FLU, PNEUMONIA, TETANUS, ETC**

<u>Immunization Type</u>	<u>Date</u>	<u>Details</u>

**FAMILY HISTORY**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>	<u>Details</u>

**DRUGS/MEDICINES/OTC**

<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Details</u>

---

---

---

---

**ALLERGIES/SENSITIVITIES**

**Drug**

**Details**

**Food**

**Details**

---

---

---

---

---

---

---