MY RECORDS

Never let anyone else tell you what is possible

STANE PARRISH

HEALTH RECORDS

Name _____

Address _____

Cell Phone _____ Email Address _____

Date of Birth _____ Sex _____Height_____Weight _____ Race _____

Birthmarks/Scars _____

Blood Type _____.

EMERGENCY CONTACT

Name _____

Relationship _____

Address _____

Cell Phone _____ Email Address _____

HEALTH INSURANCE

Primary Health Insurance Carrier _____

Phone: _____ Member Number _____

Group Number_____ Primary Insured Name _____

Name of Employer_____

Secondary Health Insurance Carrier _____

Phone: _____ Member Number _____

Group Number_____ Primary Insured Name _____

Name of Employer_____

HEALTH CARE PROVIDERS

PRIMARY CARE PROVIDER

Name _____

Group or Association _____

Address _____

Phone _____ Emergency Phone (after hours) _____

Fax _____Email Address _____

Web address _____

DENTIST

Name _____

Group or Association _____

Address _____

Phone _____ Emergency Phone (after hours) _____

Fax _____Email Address _____

Web address _____

EYE DOCTOR

Name _____

Group or Association _____

Address _____

Phone _____ Emergency Phone (after hours) _____

Fax _____Email Address _____

Web address _____

PHARMACY

Name _____

Address _____

Phone _____ Fax _____

Web address _____

Pharmacy Hours _____

HEALTH CARE PROVIDERS: SPECIALTY

Specialty _____

Name _____

Group or Association _____

Address _____

Phone _____ Emergency Phone (after hours) _____

Fax _____Email Address _____

Web address _____

Specialty _____

Name _____

Group or Association _____

Address _____

Phone _____ Emergency Phone (after hours) _____

Fax _____Email Address _____

Web address _____

Specialty _____

Name _____

Group or Association _____

Address _____

Phone _____ Emergency Phone (after hours) _____

Fax _____Email Address _____

Web address _____

Specialty _____

Name _____

Group or Association _____

Address _____

Phone _____ Emergency Phone (after hours) _____

Fax _____Email Address _____

Web address _____

HOSPITALIZATIONS

Reason____

Admission Date ______________________________ Discharge Date ___________________________________

Diagnosis ____

Complications ____

Doctor _____________________________________ Hospital ____

Reason____

Admission Date ______________________________ Discharge Date ___________________________________

Diagnosis ____

Complications ____

Doctor _____________________________________ Hospital ____

Reason____

Admission Date ______________________________ Discharge Date ___________________________________

Diagnosis ____

Complications ____

Doctor _____________________________________ Hospital ____

Reason____

Admission Date ______________________________ Discharge Date ___________________________________

Diagnosis ____

Complications ____

Doctor _____________________________________ Hospital ____

Reason____

Admission Date ______________________________ Discharge Date ___________________________________

Diagnosis ____

Complications ____

Doctor _____________________________________ Hospital ____

SURGERIES

Surgical Procedure _____ Date _____

Results _____

Doctor _____ Hospital _____

Comments _____

_____

_____

Surgical Procedure _____ Date _____

Results _____

Doctor _____ Hospital _____

Comments _____

_____

_____

Surgical Procedure _____ Date _____

Results _____

Doctor _____ Hospital _____

Comments _____

_____

_____

MEDICAL DEVICES

(include pacemakers, breathing devices, etc.)

Device Type _____

Date _____ Doctor _____Hospital _____

Reason _____

Device Type _____

Date _____ Doctor _____Hospital _____

Reason _____

HEALTH HISTORY

HEALTH LOG – Noninfectious major illnesses, include pregnancy and childbirth

Health Issue	Age at Onset	Date Diagnosed	Status	Notes (Medication, Surgery)

MEDICAL HISTORY

Yes	No	Condition/Disease	Date of Onset
		Alcohol or Drug Addition	
		Arthritis	
		Asthma	
		Bleeding Disorders	
		Blood Clots	
		Bone or Spine	
		Bronchitis	
		Cancer	
		Cataracts	
		Crohn's Disease/Colitis	
		Drug Use	
		Diabetes	
		Dizziness	
		Emphysema	
		Epilepsy	
		Fainting	
		Gallbladder disease/stones	
		Glaucoma	

Yes	No	Condition/Disease	Date of Onset
		Heart Disease	
		Heart Attack	
		Hepatitis/Jaundice/Liver	
		High Blood Pressure	
		High Cholesterol	
		HIV positive/AIDS	
		Kidney Disease	
		Lung Disease	
		Pain or Pressure in Chest	
		Palpitations	
		Prostate Disease	
		Seizures/Epilepsy	
		Shortness of Breath	
		Stroke	
		Thyroid Disease	
		Tuberculosis	
		Ulcers/Stomach pain	
		Other _____	

INFECTIOUS DISEASE

Condition/Disease	Age	Date	Notes (Treatment, Complications, etc)
Covid			
Flu			
Chicken Pox/Varicella			
Hepatitis			
Measles			
Mumps			
Pertussis/Whooping Cough			
Pneumonia			
Polio			
Rubella			
Scarlet Fever			
Other:			

IMMUNIZATIONS

	BOOSTER 1		BOOSTER 2		BOOSTER 3	
IMMUNIZATION FOR		AGE/DATE		AGED/ATE		AGE/DATE
Covid						
Diphtheria						
Hepatitis B						
Measles						
Mumps						
Pertussis/WhoopingCough						
Polio						
Rubella						
Smallpox						
Tetanus						
Tuberculosis						
Typhoid						

ALLERGIES/DRUG SENSITIVITIES

ALLERGY/SENSITIVITY (i.e. foods, medications, environmental)	Reaction	Date Last Occurred	Treatment

FAMILY MEDICAL HISTORY

Have your family members had any of the conditions listed below?

Yes	No	Condition/Disease	Relationship
		Alcohol or Drug Addition	
		Arthritis	
		Asthma	
		Cancer	
		Diabetes	
		Emphysema	
		Glaucoma	
		Heart Condition	
		Hepatitis	
		High Blood Pressure	
		High Cholesterol	

Yes	No	Condition/Disease	Relationship
		Kidney Disease	
		Rheumatic Fever	
		Seizures	
		Smoking	
		Stomach Liver/Intestinal Problems	
		Stroke	
		Thyroid Disorders	
		Tuberculosis	
		Other	

Relative	Name	Any Pertinent Info
Mother		
Father		
Siblings		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Child(ren)		

MY LEGAL DOCUMENTS/DIRECTIVES

☐ LIVING WILL

Physical Location of Document _____

Address _____

☐ DO NOT RESUSCITATE

Physical Location of Document _____

Address _____

☐ POWER OF ATTORNEY

Name _____

Address _____

Work Phone _____ Cell Phone _____ Email _____

☐ DURABLE POWER OF ATTORNEY FOR HEALTHCARE

Name _____

Address _____

Work Phone _____ Cell Phone _____ Email _____

☐ LEGAL REPRESENTATIVE (person who you have assigned legal authority)

Name _____

Address _____

Home Phone _____Work Phone _____Cell Phone _____

Email _____