MY RECORDS

My records in a place that you can store your health records as well as relevant information to your health and future.

Never let anyone else tell you what is possible

STANE PARRISH

Print more Health History Pages Here

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 _____