MY HEALTH RECORDS

Name____

Address ____

Home Phone ______________ Cell Phone _________________ Email Address ______________________

Date of Birth ________________ Sex ___________ Height_________ Weight __________ Race __________________

Birthmarks/Scars ____ Blood Type ___________

EMERGENCY CONTACT

Name____

Relationship ____

Address ____

Home Phone ______________ Cell Phone _______________ Email Address ______________________

HEALTH INSURANCE

Primary Health Insurance Carrier ______________________________________

Phone: ____

Member Number______________________________ Group Number______________________________

Primary Insured Name__________________________ Social Security No. __________________________

Name of Employer____

Secondary Health Insurance Carrier ____________________________________

Phone: ____

Member Number______________________________ Group Number______________________________

Primary Insured Name__________________________ Social Security No. __________________________

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 ____________________

LEGAL DOCUMENTS/DIRECTIVES

❑ LIVING WILL

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 ____________

MEDICAL HISTORY

YES	NO	CONDITION/DISEASE	DATE OF ONSET
❑	❑	Alcoholism	
❑	❑	Anemia	
❑	❑	Arthritis	
❑	❑	Asthma/Emphysema	
❑	❑	Bleeding/Blood Disorders/Clots	
❑	❑	Bone or Spine	
❑	❑	Bronchitis	
❑	❑	Cancer	
❑	❑	Cataracts	
❑	❑	Crohn's Disease/Colitis	
❑	❑	Diabetes	
❑	❑	Dizziness	
❑	❑	Emphysema	
❑	❑	Epilepsy	
❑	❑	Fainting	
❑	❑	Gallbladder disease/stones	
❑	❑	Glaucoma	
❑	❑	Heart Disease	
❑	❑	Heart Attack	

YES	NO	CONDITION/DISEASE	DATE OF ONSET
❑	❑	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 (Significant illness you have seen a doctor for) ____________________	

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INFECTIOUS DISEASE

DISEASE	AGE	DATE	NOTES (TREATMENT, COMPLICATIONS, ETC)
Chicken Pox			
Hepatitis			
Measles			
Mumps			
Pertussis/Whooping Cough			
Pnemonia			
Polio			
Rubella			
Scarlet Fever			
Other			

IMMUNIZATIONS

	BOOSTER 1		BOOSTER 2		BOOSTER 3	
IMMUNIZATION FOR	AGE	DATE	AGE	DATE	AGE	DATE
Diptheria						
Hepatitis B						
Measles						
Mumps						
Pertussis/Whooping Cough						
Polio						
Rubella						
Smallpox						
Tetanus						
Tuberculosis						
Thyphoid						
Other						

ALLERGIES/DRUG SENSITIVITIES

ALLERGY/SENSITIVITY (i.e. foods, medications, environmental)	REACTION	DATE LAST OCCURRED	TREATMENT

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FAMILY MEDICAL HISTORY

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

YES	NO	CONDITION/DISEASE	RELATIONSHIP
❑	❑	Alcoholism	
❑	❑	Arthritis	
❑	❑	Asthma	
❑	❑	Cancer	
❑	❑	Diabetes	
❑	❑	Emphysema	
❑	❑	Glaucoma	
❑	❑	Heart Condition	
❑	❑	Hemodialysis	
❑	❑	Hepatitis	
❑	❑	High Blood Pressure	
❑	❑	High Cholestrol	

YES	NO	CONDITION/DISEASE	RELATIONSHIP
❑	❑	Kidney Disease	
❑	❑	Mental Retardation	
❑	❑	Rheumatic Fever	
❑	❑	Seizures	
❑	❑	Smoking	
❑	❑	Stomach Liver/Intestinal Problems	
❑	❑	Stroke	
❑	❑	Thyroid Disorders	
❑	❑	Tuberculosis	
❑	❑	Tumor	
❑	❑	Other	

RELATIVE	BIRTH YEAR/AGE	IF DECEASED INDICATE AGE AND CAUSE
Mother		
Father		
Siblings		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Child(ren)		

LIFESTYLE

ALCOHOL

Drinks per week ____________

Number of years ____________

SMOKING

Amount per day ________________

Number of years _______________

EXERCISE

Type ____ Days per week ________________

Type ____ Days per week ________________

HEALTH LOG - *Noninfectious major illnesses, include pregnancy and childbirth*

HEALTH ISSUE/ CONDITION	AGE AT ONSET/ DATE DIAGNOSED	CONDITION	STATUS	NOTE *(medications, x-rays, surgery)*

MEDICATIONS

DATE STARTED	DATE STOPPED	MEDICATION	DOSAGE	REASON STARTED/STOPPED

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DOCTOR VISITS

DATE	DOCTOR	REASON	DIAGNOSIS

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 ______________

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 ____

LAB

(include x-rays, MRI, mammograms)

Test Type ____________________ Date ________

Requesting Doctor ____________ Administered by ____________

Reason ____________________

Result ____________________

____

Test Type ____________________ Date ________

Requesting Doctor ____________ Administered by ____________

Reason ____________________

Result ____________________

____

Test Type ____________________ Date ________

Requesting Doctor ____________ Administered by ____________

Reason ____________________

Result ____________________

____

Test Type ____________________ Date ________

Requesting Doctor ____________ Administered by ____________

Reason ____________________

Result ____________________

____

SARCOIDOSIS CHECKLIST

Date of initial diagnosis ______________________ Diagnosing Doctor ____

Symptoms/reason that led to the diagnosis ____

____

____

____

MAJOR AFFECTED ORGANS	SYMPTOMS	PROVIDER RESPONSIBLE
❑ LUNGS		
❑ EYES		
❑ NEUROLOGICAL		
❑ SALIVARY/DENTAL		
❑ HEART		
❑ SKIN		
❑ BOWELS/LIVER		
❑ KIDNEY		
❑ ARTHRITIS		

RECENT DIAGNOSTIC TESTS

TEST	DATE LAST PERFORMED	NEXT SCHEDULED	RESULTS
❑ CBC with Differential and plt			
❑ Liver Function tests			
❑ Urine/Blood Calcium			
❑ Kidney Function			
❑ Angiotensin Converting Enzyme Test			
❑ Radiology			
❑ Chest CT			
❑ Chest x-ray			
❑ Gallium Scan			
❑ PET scan			
❑ Cardiac PET scan			
❑ Echocardiogram			
❑ TB Test			
❑ Eye exam/Slit Lamp			
❑ PPD/Anergy Panel			