Medical History

- ☐ Arthritis
- ☐ Abnormal Heart Rhythm
- ☐ Addictions: _____
- ☐ Cancer: _____
- ☐ COVID-19
- ☐ Mental Health: _____
- ☐ Dementia/Alzheimer's
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lung Disease: _____
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Wound Healing Problems
- ☐ Other / Notes: _____

Date	Surgical History / Hospitalizations / Screenings

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My Personal Health Record

Name: _____

Date of Birth: _____ Blood Type: _____

Caregiver Information

Name: _____

Relationship to me: _____

Phone Numbers: _____

Advance Directives / Living Will: ☐ Yes ☐ No

If yes, where can this be found? _____

Durable Power of Attorney for Health Care: ☐ Yes ☐ No

Name: _____

Phone Numbers: _____

Health Care Providers

TYPE	NAME	PHONE NUMBER
Primary Care Physician (PCP)		
Specialist		
Specialist		
Specialist		

REMEMBER: Take this form and your medications (including bottles) to your doctor visits. Connect to your patient portal(s) to get access to your health care information and communicate with your provider(s).

Medication List

(In the table below include vitamins, over-the-counter and supplements)

Pharmacy: _____

Pharmacy Phone Number: _____

Allergies (include sensitivities to food, medications or materials (like latex)): _____

_____

_____

Vaccine Dates

Flu: _____ Pneumonia: _____

COVID-19: _____

Other: (shingles, tetanus, Hepatitis B, etc.):

_____

_____

Tip: Use a pencil to enter information below.
Use additional paper if needed.

How Often? M = Morning | N = Noon | E = Evening | BT = Bed Time | PRN = Only Take As Needed

Name	Dose	How Often M N E BT PRN	Reason	Prescribing Doctor	Notes/Side Effects Start-Stop Dates
		☐ ☐ ☐ ☐ ☐			
		☐ ☐ ☐ ☐ ☐			
		☐ ☐ ☐ ☐ ☐			
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