

**Health History Record** (please print) © 2001 Cards4Life. All Rights Reserved

|   |             |                                      |                             |   |           |
|---|-------------|--------------------------------------|-----------------------------|---|-----------|
| Name (last, first):   |             | DOB mm/dd/yyyy:                      | Blood Type:                 | Social Security Number:                       |           |
| Address:  |             | APT/FLR                              | City:                       | State:  | Zip:      |
| Marital status:   | Occupation: | Work Phone:                          |                             | Home Phone:                                   |           |
| Name of Doctor or Primary Care Practitioner:                      |             | Office address where you are seen:   |                             | Practitioner's Phone:                         |           |
| Name of Cardiologist::  |             | Office address where you are seen:   |                             | Cardiologist's Phone:                         |           |
| Do you have a Living Will or Advance Medical Directive (AD)?      |             | Where is your Living Will located?   |                             | Do you have an Organ Donor Advance Directive? |           |
| Do you have a directive for "No CPR" or Do Not Resuscitate (DNR)? |             | Where is your DNR directive located? |                             |   | Religion: |
| Name of Power of Attorney (POA):                                  |             |                                      | Relationship to you:        | POA's Phone:                                  |           |
| Primary language:   |             |                                      | Do you need an interpreter? |   |           |

**INSURANCE INFORMATION**

No medical insurance

|                              |                      |                   |
|------------------------------|----------------------|-------------------|
| Name of Primary Insurance:   | Ins 1 Group :#       | Ins 1 Phone:      |
| Ins 1 Employer/Phone:        | Ins 1 Member's Name: | Ins 1 Member ID # |
| Name of Secondary Insurance: | Ins 2 Group #:       | Ins 2 Phone:      |
| Ins 2 Employer/Phone:        | Ins 2 Member's Name: | Ins 2 Member ID # |

**FAMILY HOUSEHOLD MEMBERS** (identify primary caregiver with asterisk)

| NAME | BIRTH YR | RELATIONSHIP/ROLE | COMMENTS |
|------|----------|-------------------|----------|
|      |          |                   |          |
|      |          |                   |          |
|      |          |                   |          |
|      |          |                   |          |

**EMERGENCY CONTACTS** (relatives or others interested)

| NAME / RELATIONSHIP | ADDRESS | PHONE                                |
|---------------------|---------|--------------------------------------|
|                     |         | (W) (____) _____<br>(H) (____) _____ |
|                     |         | (W) (____) _____<br>(H) (____) _____ |

**MEDICAL INFORMATION** (include year occurrence)

Medical History:

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Surgical History:

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Mother's Health History: \_\_\_\_\_ Father's Health History: \_\_\_\_\_

Siblings' Health History: \_\_\_\_\_

Assist Devices (i.e. glasses, contact lenses, hearing aides, wheelchair, walker, artificial limb, etc.):

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**ALLERGIES:**

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**COMMUNITY RESOURCES** (adult daycare, outpatient health services, meals on wheels, medical transportation, etc.)

| RESOURCE | CONTACT PERSON | PHONE |
|----------|----------------|-------|
|          |                |       |
|          |                |       |

**RECENT HOSPITALIZATIONS**

| ADMIT DATE<br>mm/dd/yyyy | DISCHARGE DATE<br>mm/dd/yyyy | PRIMARY DIAGNOSIS |
|--------------------------|------------------------------|-------------------|
|                          |                              |                   |
|                          |                              |                   |
|                          |                              |                   |
|                          |                              |                   |