

PHR-Adult
Health Information Form for Adults

A. Identification

B. Emergency Contacts

Name (Last)				(First)		(Middle)		Name (Last)				(First)		(Middle)	
Maiden Name															
Primary Address								Relationship							
City		State		Zip		Country		Address							
Alternate Address								City		State		Zip Code		Country	
City		State		Zip Code		Country		Home Phone				Work Phone			
Home Phone				Work Phone				Cell Phone				Email Address			
Cell Phone				Email Address											
Date of Birth				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female											
Height		Weight		Eye Color		Hair Color		Name (Last)		(First)		(Middle)			
Race			Birthmark/Scars					Relationship							
Blood/RH Type			Special Conditions			Marital Status		Address							
Occupation								City		State		Zip Code		Country	
Company Name								Home Phone				Work Phone			
City		State		Zip Code		Country		Cell Phone				Email Address			
Phone Number			Languages Spoken					In Case of Emergency, Notify: (Medical Contact)							
Primary Health Insurance Carrier				Policy Number				Doctor							
Secondary Health Insurance Carrier				Policy Number											
								Phone Number							
								Dentist				Telephone Number			
								Pharmacy				Telephone Number			

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Health Information Form for Adults

C. Healthcare Provider

Healthcare Provider Specialty		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone (after hours)
Name				Email Address	
Group or Association				Fax	
Address				Web Address/URL	
City	State	Zip Code	Country		
Healthcare Provider Specialty		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone (after hours)
Name				Email Address	
Group or Association				Fax	
Address				Web Address/URL	
City	State	Zip Code	Country		
Healthcare Provider Specialty		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone (after hours)
Name				Email Address	
Group or Association				Fax	
Address				Web Address/URL	
City	State	Zip Code	Country		
Healthcare Provider Specialty		Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone	Emergency Phone (after hours)
Name				Email Address	
Group or Association				Fax	
Address				Web Address/URL	
City	State	Zip Code	Country		

D. Insurance Providers

Insurance Provider Type		Email Address	Fax
Company Name		Web Address/URL	

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Health Information Form for Adults

Address				Primary Insured Person Name	Social Security Number		
City	State	Zip Code	Country	Name of Employer			
Contact Name		Phone		Address			
Identification-Group Number		Member (ID) Number		City	State	Zip Code	Country
Contact Information-Phone		Emergency Phone (after hours)		Phone			
Insurance Provider Type				Email Address	Fax		
Company Name				Web Address/URL			
Address				Primary Insured Person Name	Social Security Number		
City	State	Zip Code	Country	Name of Employer			
Contact Name		Phone		Address			
Identification-Group Number		Member (ID) Number		City	State	Zip Code	Country
Contact Information Phone		Emergency Phone (after hours)		Phone			
Insurance Provider Type				Email Address	Fax		
Company Name				Web Address/URL			
Address				Primary Insured Person Name	Social Security Number		
City	State	Zip Code	Country	Name of Employer			
Contact Name		Phone		Address			
Identification-Group Number		Member (ID) Number		City	State	Zip Code	Country
Contact Information Phone		Emergency Phone (after hours)		Phone			

E. Legal Documents/Medical Directives

<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare <input type="checkbox"/> Power of Attorney				Fax			
Document Location (Physical Location)				Contact (Name of person who has access to the document)			
Location Name (for example Bank of America)				Address			
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			

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Health Information Form for Adults

Legal Representative (Name of person with legal authority)				Home Phone		Cell Phone	
Address				Pager		Email Address	
City	State	Zip Code	Country	Work Phone		Work Email Address	
Contact Information				Fax			
Home Phone		Cell Phone		Date Filed			
Pager		Email Address		Organ Donation			
Work E-mail Address		Work Phone		Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No		State Where Registered	

<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare <input type="checkbox"/> Power of Attorney				Fax			
Document Location (Physical Location)				Contact (Name of person who has access to the document)			
Location Name (for example Bank of America)				Address			
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			
Legal Representative (Name of person with legal authority)				Home Phone		Cellular Phone	
Address				Pager		Email Address	
City	State	Zip Code	Country	Work Phone		Work Email Address	
Contact Information				Fax			
Home Phone		Cell Phone		Date Filed			
Pager		Email Address		Organ Donation			
Work Email Address		Work Phone		Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No		State Where Registered	

F. Medical History (Check appropriate)

	Date of Onset		Date of Onset
<input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive:		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Hypoglycemia	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Chlamydia		<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Pain or Pressure in Chest	
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Palpitations	

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Health Information Form for Adults

<input type="checkbox"/>	Emphysema		<input type="checkbox"/>	Periods of Unconsciousness	
<input type="checkbox"/>	Epilepsy		<input type="checkbox"/>	Rheumatic Fever	
<input type="checkbox"/>	Eye Problem		<input type="checkbox"/>	Rheumatism	
<input type="checkbox"/>	Fainting		<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Frequent or Severe Headaches		<input type="checkbox"/>	Shortness of Breath	
<input type="checkbox"/>	Glaucoma		<input type="checkbox"/>	Stomach, Liver, or Intestinal Problems	
<input type="checkbox"/>	Gonorrhea		<input type="checkbox"/>	Syphilis	
<input type="checkbox"/>	Hearing Impairment		<input type="checkbox"/>	Tuberculosis	
<input type="checkbox"/>	Heart Condition		<input type="checkbox"/>	Tumor	
<input type="checkbox"/>	Hemodialysis		<input type="checkbox"/>	Thyroid Problems	
<input type="checkbox"/>	Herpes		<input type="checkbox"/>	Urinary Tract Infection	
<input type="checkbox"/>	High Blood Cholesterol		<input type="checkbox"/>	Other	

G. Infectious Diseases

Disease	Age	Date	Remarks
Chicken Pox			
Hepatitis			
Measles			
Mumps			
Pertussis/Whooping Cough			
Pneumonia			
Polio			
Rubella			
Scarlet Fever			
Other			

H. Immunizations

Immunization	Booster 1		Booster 2		Booster 3	
	Age	Date	Age	Date	Age	Date
Diphtheria						
Hepatitis B						
Measles						
Mumps						
Pertussis/Whooping Cough						
Polio						
Rubella						
Smallpox						
Tetanus						
Tuberculosis						
Typhoid						
Other						

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Health Information Form for Adults

I. Allergies/Drug Sensitivities

Allergy/Sensitivity Type <i>(include medications, foods, environmental, or other)</i>	Reaction	Date Last Occurred	Treatment

J. Family Member History

	Mother	Father	Sibling(s)	Grandparent(s)	Children
Enter ages of relatives					
If deceased, indicate age and cause of death					
Check all items that apply for present state of health or any past illnesses.					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
Hemodialysis					
Hepatitis					
High Blood Cholesterol					
High Blood Pressure					
Kidney Disease					
Mental Retardation					
Rheumatic Fever					
Seizures					
Smoking					
Stomach, Liver, or Intestinal Problems					
Stroke					
Thyroid Disorders					
Tuberculosis					
Tumor					
Other					

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Health Information Form for Adults

O. Hospitalizations

Hospitalization Type (including emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (including emergency room visits)		Diagnosis
Admission Date	Admission Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (including emergency room visits)		Diagnosis
Admission Date	Discharge Date	Admission Date
Doctor		
Hospital		
Reason		Complications

P. Surgeries

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

continued

Health Information Form for Adults

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Q. Lab or Imaging (for example, x-ray, MRI, mammogram)

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

R. Medical Devices (for example, pacemaker, insulin pumas, breathing devices)

Device Type	Doctor	Device Type	Doctor
Hospital	Date	Hospital	Date
Reason		Reason	

S. Physical/Occupation Therapy

Therapy Type	Start Date	Stop Date	Frequency	Therapist

T. Vision

Date of Visit	Physician	Date of Visit	Physician
Vision Rx		Vision Rx	
Date of Visit	Physician	Date of Visit	Physician
Vision Rx		Vision Rx	

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