Your Family Member's Personal Health Record

A. Identification

Name (Last) (First) (Middle)

Primary Address

City State Zip Code

Home Phone Work Phone Mobile Phone

Date of Birth (M/D/YY) Sex: ❑ Male ❑ Female

Blood Type, if known Languages Spoken

Occupation (If Relevant) Company Phone

Company Name Company Fax

Company Address City State Zip Code

B. Emergency Contacts

In Case of Emergency, Notify (Primary Contact)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	
In Case of Emergency, Notify (Secondary Contact)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	

C. Health Insurance Information

Primary Health Insurance Provider Type: ❑ Private ❑ Medicare ❑ Medicaid ❑ Other

Company Name (if Private) | Member (ID) Number: | Group Plan Number:

Phone Number | Primary Insured (name, if different from part A of this form)

Primary Insured's Employer (if relevant) | Employer Phone Number

Secondary Health Insurance Provider Type: ❑ Private ❑ Medicare ❑ Medicaid ❑ Other

Company Name (if Private) | Member (ID) Number: | Group Plan Number:

Phone Number | Primary Insured (name, if different from part A of this form)

Primary Insured's Employer (if relevant) | Employer Phone Number

Secondary Health Insurance Provider Type: ❑ Private ❑ Medicare ❑ Medicaid ❑ Other

Company Name (if Private) | Member (ID) Number: | Group Plan Number:

Phone Number | Primary Insured (name, if different from part A of this form)

Primary Insured's Employer (if relevant) | Employer Phone Number

D. Advance Directives

(includes Health Care Proxy, Living Will and Power of Attorney)

Health Care Proxy *(complete the information about the person named as the agent on your family member's Health Care Proxy form)*

Name	Phone	Mobile Phone	Work Phone
Agent Address	City	State	Zip Code
Agent Work Address	City	State	Zip Code
Document Location (physical location, for ex. safe deposit box)			
Document Contact (person with access to document)	Phone Number		

Living Will

Document Location (physical location, for ex. safe deposit box)
Document Contact (person with access to document) Phone Number

Power of Attorney (complete the information about the person who has the Power of Attorney)

Name	Phone	Mobile Phone	Work Phone
Address	City	State	Zip Code
Work Address	City	State	Zip Code
Document Location (physical location, for ex. safe deposit box)			
Document Contact (person with access to document)	Phone Number		

E. Allergies/Drug Sensitivities

(include medications, foods, environmental factors and/or other)

Allergen	Reaction	Last Occurrence	Treatment

F. Your Family Member's Health History

Check all items that apply to your family member's present state of health and any previous illnesses.

❑ Alcoholism	❑ High Blood Pressure
❑ Arthritis	❑ Kidney Disease
❑ Asthma	❑ Mental Retardation
❑ Cancer	❑ Rheumatic Fever
❑ Diabetes Type: ❑ I ❑ II	❑ Seizures
❑ Emphysema	❑ Stomach, Liver, or Intestinal problems
❑ Glaucoma	❑ Stroke
❑ Heart Condition	❑ Thyroid Disorders
❑ Hemodialysis	❑ Tuberculosis
❑ Hepatitis Type: ❑ A ❑ B	❑ Tumor
❑ High Blood Cholesterol	❑ Other

G. Your Family Member's Lifestyle

Alcohol	❑ Yes	❑ No	Drink(s) Per Week:	Number of Years:
Smoking	❑ Yes	❑ No	Pack(s) Per Day:	Number of Years:

H. Your Family Member's Health Event Log

Please indicate any hospitalizations, surgeries, or other major health events, including Emergency Room visits.

Health Event	Date	Diagnosis	Facility	Outcome