PERSONAL HEALTH RECORD of (name) ____ **Age:** ____

Address: ____ **Phone#:** ____

E-Mail: ____ **Primary Language Spoken:** ____ **Date Record Updated:** ____

EMERGENCY CONTACT:	**HEALTH CARE PROXY 1:**	**HEALTH CARE PROXY 2:**
Name: ____ **Phone#:** ____ **Relationship:** ☐ Wife ☐ Son ☐ Husband ☐ Partner ☐ Daughter ☐ Other	**Name:** ____ **Phone#:** ____ **Relationship:** ____	**Name:** ____ **Phone#:** ____ **Relationship:** ____
PRIMARY DOCTOR:	**SPECIALIST DOCTOR:**	**OTHER DOCTOR:**
Name: ____ **Phone#:** ____ **Date Last Seen:** ____	**Name:** ____ **Phone#:** ____ **Date Last Seen:** ____ **Reason:** ____	**Name:** ____ **Phone#:** ____ **Date Last Seen:** ____ **Reason:** ____

Name [ ] **Primary Doctor** [ ] **Phone#** [ ]

ALLERGIES:

- [ ] **NONE**
- [ ] Latex
- [ ] Bandaid Adhesive
- [ ] Medicine **(name)**

- [ ] Food **(name)**

- [ ] Insect **(name)**

- [ ] Other **(name)**

HEALTH PROBLEMS:

- [ ] **NONE**
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding Problem
- [ ] Breathing Difficulty
- [ ] COPD
- [ ] Cancer **(where)**
- [ ] Depression
- [ ] Diabetes (sugar in the blood)
- [ ] Heart Problems
- [ ] Hearing Problems
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Osteoporosis
- [ ] Seizures
- [ ] Thyroid Problem
- [ ] Other

MEDICATIONS:
(Prescription, over the counter & Herbal)
Include Dose/Amount
(mg. Number of pill) /(# pills each day)

- [ ] **NONE**

HOSPITAL STAYS:

- [ ] **NONE**

Screening Tests (DATE)

Mammogram

PAP Smear

Prostate

Colonoscopy

Vaccines: (DATE)

Flu

Pneumonia

Tetanus

Diptheria

Do you have any problem with?

- [ ] **NONE**

Seeing

Hearing

Speaking