ADULT PERSONAL HEALTH RECORD AND MEDICAL HISTORY

Bring this form with you each time you visit your Health Care Professional

ALLERGIES:

Patient Name_____ Phone ( )_____
(Last) (First) (Middle)

Address_____
(Street) (City) (State) (Zip Code)

Date of Birth: Month_____ Day_____ Year_____ Gender: Male_____ Female_____ Ethnicity_____

Social Security #_____

HEALTH INSURANCE INFORMATION:

MEDICAID # _____

Name of Medicaid HMO_____ HMO ID#_____

Name & phone number of Medicaid HMO Care Manager (If known)_____

MEDICARE (if applicable)

Medicare #_____ Medicare Part D Drug Plan_____

Name of Medicare Advantage HMO (if applicable) _____

PRIVATE HEALTH INSURANCE (if applicable)

Provider_____ Insurance ID #_____

GUARDIANSHIP

Self_____ Other_____ If Other, please List:

Guardian's Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

HAS A LIVING WILL No_____ Yes_____ Location_____

HEALTH CARE PROXY Name_____ Phone ( ) _____

CASE MANAGEMENT

Agency _____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

EMERGENCY CONTACT **Relationship_____**

Name_____ Phone ( ) _____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

NEXT OF KIN **Relationship**_____

Name_____ Phone ( ) _____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

PRIMARY CARE PHYSICIAN

Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

DENTIST

Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

PHARMACY

Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

SPECIALIST PHYSICIAN

(1) Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

(2) Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

(3) Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

(4) Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

(5) Name_____ Phone ( ) _____

Address_____
(Street) (City) (State) (Zip Code)

Cause of Primary Disability: Unknown_____ Known_____

Type of Disability: Intellectual Disability_____ Down Syndrome_____ Cerebral Palsy_____

Spina Bifida_____ Autism Spectrum Disorder (Please specify type) _____

Other (please specify) _____

AMBULATION: Independent_____ Cane_____ Walker_____ Wheel Chair_____

Braces_____ Prosthesis_____

VISION: Glasses_____ Legally Blind_____

SEIZURE DISORDER: Yes _____ No _____ Controlled: Yes _____ No _____

Type of seizure(s): Generalized_____Tonic_____Clonic_____Absence_____

Last EEG/CT Head/MRI Brain Scan Date: _____Result:_____

Wears Helmet: No_____ Yes_____

COMMUNICATION

Method of Communication: Speech_____ Gesture_____ Communication Device_____ Signs_____

Other (specify) _____

Language of Communication: English_____ Spanish_____ Other (specify) _____

Hearing Problems: Yes _____ No _____ If yes, explain_____

Wears hearing aids_____

PERSONAL CARE

Bladder Control: Yes_____ No_____ Bowel Control: Yes_____ No_____

Special Diet (explain briefly) _____

Dentures: Yes_____ No_____

ADULT IMMUNIZATIONS

DPT (Tetanus) Date_____ Pneumonia Date_____ Shingles Date_____

FAMILY HISTORY

MOTHER

Name_____ Date of Birth_____

Living: Yes_____ No_____ If deceased, cause of death_____

FATHER

Name_____ Date of Birth_____

Living: Yes_____ No_____ If deceased, cause of death_____

FAMILY MEDICAL HISTORY Date Completed: _____

Please indicate with a check (√) family members who have had any of the following conditions:

Medical Condition	Mother	Father	Sister	Brother	Grand-mother	Grand-father	Other Relative
Alcoholism							
Alzheimer's Disease							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Ovary							
Cancer, Prostate							
Cancer, Melanoma							
Cancer, skin (except melanoma)							
Cancer (not noted)							
Depression							
Developmental Disability							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy (seizures)							
Genetic diseases							
Glaucoma							
Hay fever (Allergic Rhinitis)							
Hearing Problems							
Heart Disease							
High Blood Pressure							
High cholesterol							
Kidney diseases							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other:							

PATIENT HOSPITALIZATIONS

DATE	DIAGNOSIS/TREATMENT	FACILITY

CHRONIC (ongoing) MEDICAL DIAGNOSES

DATE	DESCRIPTION/TREATMENT	FACILITY

LONG TERM MEDICATIONS

Start Date	Stop Date	Medication	Dosage	Fre-quency	Medical Condition	Physician

PERIODIC EXAMINATIONS AND ACUTE (short-term) MEDICAL PROBLEMS

Date	Diagnosis	Bloodwork	Other Tests	Results	Treatment	Physician