Health History

Last Updated:_____

Patient Name:_____ Date of Birth:_____

Phone Number: (H)_____ (C)_____(W)_____

Email Address:_____ Home Address:_____

_____

_____

Marital Status: _____

Emergency Contacts

Name and Relation:_____ Number:_____

Name and Relation:_____ Number:_____

Current Medical Conditions:

Past Medical Conditions:

Allergies:

Special Needs/Instructions (Diet, limb restrictions, mobility, sensory, cognitive, vision, hearing)

Implants (Name, type, location, settings, company name and rep phone number (cardiac implants))

Are you a Do Not Resuscitate? Y or N
Do you have a Medical Power of Attorney? Y or N Who?
Do you have a POLST? Y or N

If you are using this form during an emergency call 911 FIRST, then if able write down:

Last time you ate/drank anything:
Time (onset) when your symptoms started:
Any medications you took: