Personal Health Record

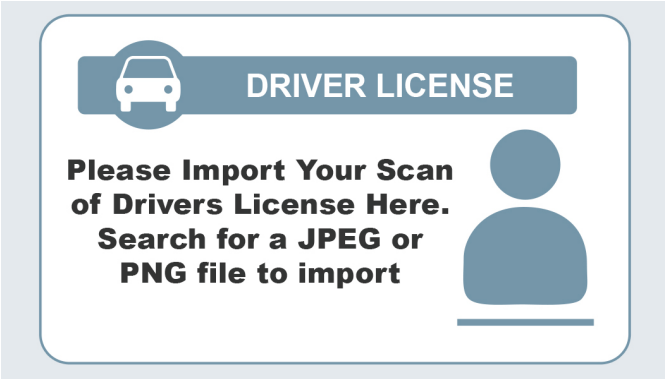
- Thank you for downloading the SearchMed Personal Health Record – an innovative new tool to organize and keep track of all your important healthcare information and data.
- Simply type all your important healthcare information into each field on the following pages, then save this PDF file to your computer, phone, cloud, or USB drive.
- Email this file to your healthcare provider ahead of time, and never spend valuable time filling out forms before your appointment.
- Use your SearchMed Personal Health Record for paperless office visits.

TABLE OF CONTENTS

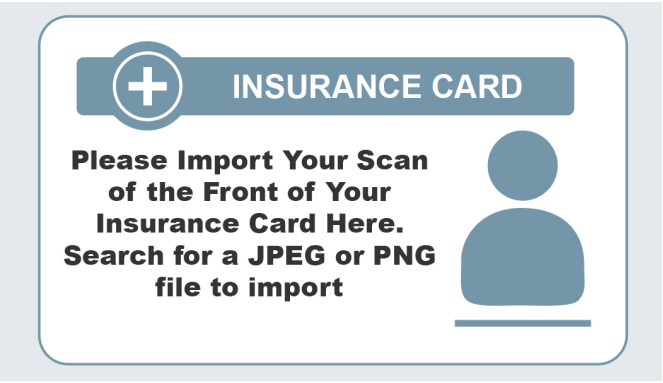
INSURANCE CARD & IDENTIFICATION PAGE

Skip This Section

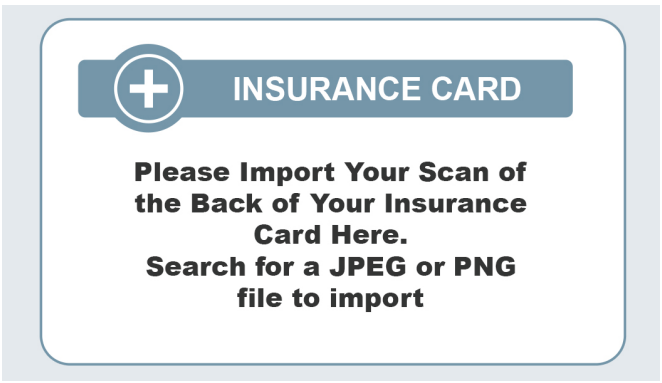
DRIVER'S LICENSE OR ID CARD



PRIMARY INSURANCE CARD FRONT

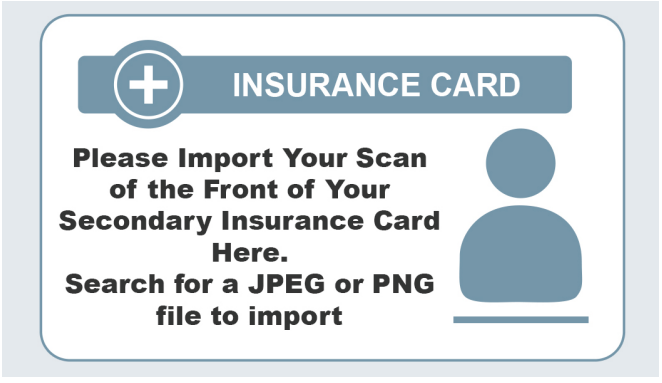


PRIMARY INSURANCE CARD BACK

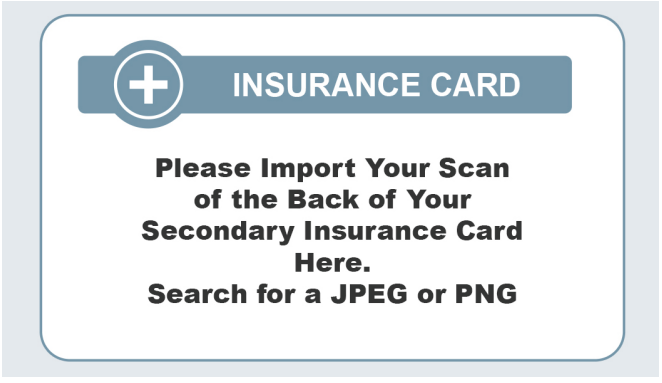


Please Select One ◯ MEDICAID ◯ MEDICARE ◯ PRIVATE INSURANCE

SECONDARY INSURANCE CARD FRONT



SECONDARY INSURANCE CARD BACK



PATIENT INFORMATION

LAST NAME

FIRST NAME

MIDDLE NAME OR INITIAL

MAIDEN OR ALTERNATE NAME

DATE OF BIRTH

MONTH DAY YEAR

SOCIAL SECURITY NUMBER

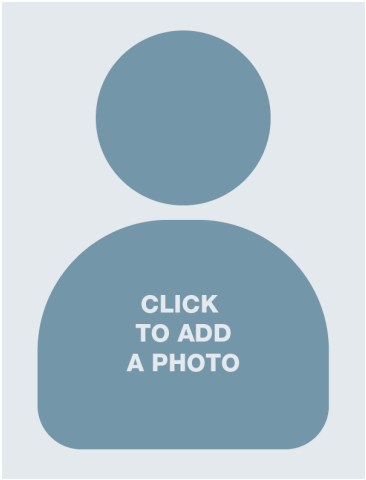
MARITAL STATUS *(i.e. Single, Married, Divorced, Widowed)*

SPOUSE'S NAME IF MARRIED

EMAIL ADDRESS

OCCUPATION

EMPLOYER



HOME PHONE NUMBER

WORK PHONE NUMBER

MOBILE PHONE NUMBER

HEIGHT

FEET INCHES

WEIGHT

EYE COLOR

HAIR COLOR

BLOOD TYPE

GENDER: ☐ MALE (X,Y) ☐ FEMALE (X,X)

CHILD/MINOR: ☐ YES* ☐ NO

ORGAN DONOR: ☐ YES ☐ NO

← IF DONOR, STATE WHERE REGISTERED

**If Patient Is a Child/Minor, Please Complete Pediatric Information on Page 15.*

PRIMARY ADDRESS

PRIMARY ADDRESS | STREET 1

PRIMARY ADDRESS | STREET 2

APARTMENT/SUITE/UNIT NUMBER

PRIMARY ADDRESS | CITY

STATE

ZIP CODE

SECONDARY ADDRESS

SECONDARY ADDRESS | STREET 1

SECONDARY ADDRESS | STREET 2

APARTMENT/SUITE/UNIT NUMBER

SECONDARY ADDRESS | CITY

STATE

ZIP CODE

COMMENTS

PRIMARY EMERGENCY CONTACT

LAST NAME

FIRST NAME

RELATIONSHIP TO PATIENT

STREET ADDRESS 1

STREET ADDRESS 2

APARTMENT/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

HOME PHONE NUMBER

WORK PHONE NUMBER

MOBILE PHONE NUMBER

EMAIL ADDRESS

COMMENTS

SECONDARY EMERGENCY CONTACT

LAST NAME

FIRST NAME

RELATIONSHIP TO PATIENT

STREET ADDRESS 1

STREET ADDRESS 2

APARTMENT/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

HOME PHONE NUMBER

WORK PHONE NUMBER

MOBILE PHONE NUMBER

EMAIL ADDRESS

COMMENTS

MEDICAL EMERGENCY CONTACT

LAST NAME

FIRST NAME

PRIMARY CARE PHYSICIAN?
☐ YES ☐ NO

HEALTHCARE PROVIDER TYPE

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

VOICEMAIL PREFERENCES

☐ I consent to receiving detailed voicemail messages from my doctor and/or their staff with information regarding diagnoses, treatment, prescriptions, test results, and other important matters, at the following phone number:

CHECK PREFERENCE: ☐ HOME VOICEMAIL ☐ MOBILE VOICEMAIL ☐ WORK VOICEMAIL **ENTER NUMBER:**

☐ I do NOT consent to receive any messages in my voicemail other than office name and callback number.

Name:

SIGNED: my checking the box and dating will suffice as my handwritten signature ☐ Month Day Year

COMMENTS

PRIMARY INSURANCE PROVIDER *(Private)*

Click Here for Medicare/Medicaid

INSURANCE COMPANY NAME

☐ CHECK HERE IF YOU ARE UNINSURED

GROUP NUMBER

MEMBER NUMBER

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

WEB ADDRESS/URL

PRIMARY POLICYHOLDER INFORMATION

PRIMARY INSURED LAST NAME

PRIMARY INSURED FIRST NAME

PRIMARY INSURED SOCIAL SECURITY NUMBER *(Last 4 Digits)*

PRIMARY INSURED RELATIONSHIP TO PATIENT

PRIMARY INSURED EMPLOYER NAME *(If Insured Through Employer)*

INSURANCE COMPANY CONTACT

INSURANCE COMPANY CONTACT NAME

INSURANCE COMPANY CONTACT EMAIL

INSURANCE COMPANY CONTACT PHONE NUMBER

INSURANCE COMPANY CONTACT FAX NUMBER

COMMENTS

MEDICARE *(Primary Insurance Provider)*

Skip This Section

MEDICARE PART A ☐ MEMBER NUMBER COVERAGE START DATE

MEDICARE PART B ☐ MEMBER NUMBER COVERAGE START DATE

PHONE NUMBER FAX NUMBER

COMMENTS

MEDICAID *(Primary Insurance Provider)*

Skip This Section

MEMBER NUMBER GROUP/BIN NUMBER *Check If N/A* ☐ HEALTH PLAN *Check If N/A* ☐

PLAN TYPE *Check If N/A* ☐ DATE ISSUED MONTH DAY YEAR

COVERAGE: ☐ MEDICAL ☐ VISION ☐ DENTAL

PRIMARY CARE PHYSICIAN ATTACHED TO MEDICAID PLAN

LAST NAME FIRST NAME ☐ CHECK HERE IF INFORMATION IS THE SAME AS PRIMARY CARE PHYSICIAN ON PAGE 9

PROVIDER TYPE GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2 BUILDING/SUITE/UNIT NUMBER

CITY STATE ZIP CODE

PRIMARY PHONE NUMBER ALTERNATE PHONE NUMBER

FAX NUMBER EMAIL ADDRESS

COMMENTS

SECONDARY INSURANCE PROVIDER *(Private or Medicare Supplement)*

Skip This Section

INSURANCE COMPANY NAME

GROUP NUMBER

MEMBER NUMBER

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

WEB ADDRESS/URL

PRIMARY POLICYHOLDER INFORMATION

PRIMARY INSURED LAST NAME

PRIMARY INSURED FIRST NAME

PRIMARY INSURED SOCIAL SECURITY NUMBER *(Last Four Digits)*

PRIMARY INSURED EMPLOYER NAME *(If Insured Through Employer)*

INSURANCE COMPANY CONTACT

INSURANCE COMPANY CONTACT NAME

INSURANCE COMPANY CONTACT EMAIL

INSURANCE COMPANY CONTACT PHONE NUMBER

INSURANCE COMPANY CONTACT FAX NUMBER

COMMENTS

TERTIARY INSURANCE PROVIDER *(Private or Medicare Supplement)*

Skip This Section

INSURANCE COMPANY NAME

GROUP NUMBER

MEMBER NUMBER

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

WEB ADDRESS/URL

PRIMARY POLICYHOLDER INFORMATION

PRIMARY INSURED LAST NAME

PRIMARY INSURED FIRST NAME

PRIMARY INSURED SOCIAL SECURITY NUMBER *(Last Four Digits)*

PRIMARY INSURED EMPLOYER NAME *(If Insured Through Employer)*

INSURANCE COMPANY CONTACT

INSURANCE COMPANY CONTACT NAME

INSURANCE COMPANY CONTACT EMAIL

INSURANCE COMPANY CONTACT PHONE NUMBER

INSURANCE COMPANY CONTACT FAX NUMBER

COMMENTS

PRIMARY CARE PHYSICIAN

LAST NAME

FIRST NAME

HEALTHCARE PROVIDER TYPE

Physician

SPECIALTY

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL HEALTHCARE PROVIDER

LAST NAME

FIRST NAME

HEALTHCARE PROVIDER TYPE

Click to Select

SPECIALTY

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL HEALTHCARE PROVIDER

Skip This Section

LAST NAME

FIRST NAME

HEALTHCARE PROVIDER TYPE

Click to Select

SPECIALTY

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL HEALTHCARE PROVIDER

Skip This Section

LAST NAME

FIRST NAME

HEALTHCARE PROVIDER TYPE

Click to Select

SPECIALTY

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL HEALTHCARE PROVIDER

Skip This Section

LAST NAME

FIRST NAME

HEALTHCARE PROVIDER TYPE

Click to Select

SPECIALTY

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL HEALTHCARE PROVIDER

Skip This Section

LAST NAME

FIRST NAME

HEALTHCARE PROVIDER TYPE

Click to Select

SPECIALTY

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

PRIMARY PHARMACY

Find Your Pharmacy At SEARCHMED.com

PHARMACY NAME

PHARMACY TYPE *(i.e. Hospital, Mail Order, Storefront, V.A.)*

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

WEB ADDRESS/URL

REQUEST 90-DAY SUPPLY WHEN AVAILABLE: ☐ YES ☐ NO

REQUEST GENERIC EQUIVALENT WHEN AVAILABLE: ☐ YES ☐ NO

COMMENTS

SECONDARY PHARMACY

PHARMACY NAME

PHARMACY TYPE *(i.e. Hospital, Mail Order, Storefront, V.A.)*

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

WEB ADDRESS/URL

REQUEST 90-DAY SUPPLY WHEN AVAILABLE: ☐ YES ☐ NO

REQUEST GENERIC EQUIVALENT WHEN AVAILABLE: ☐ YES ☐ NO

COMMENTS

PRESCRIPTION MEDICATIONS AND/OR NUTRITIONAL SUPPLEMENTS

Skip This Section

PRESCRIPTION MEDICATION OR NUTRITIONAL SUPPLEMENT *(i.e. Lipitor, Melatonin, Multi-Vitamin, Zantac)*	DOSAGE & FREQUENCY *(i.e. XXmg Once a Day)*

COMMENTS

PEDIATRIC INFORMATION *(Continued)*

Skip This Section

BIRTH HISTORY

WAS THE CHILD ADOPTED? ☐ NO ☐ YES – COUNTRY OF BIRTH: MONTH DAY YEAR

BIRTH WEIGHT *Check If Unknown* ☐

GESTATION PERIOD *(Weeks)* ☐ PRE-MATURE ☐ UNKNOWN

DELIVERY TYPE ☐ VAGINAL ☐ CESAREAN – REASON:

DID THE CHILD EXPERIENCE COMPLICATIONS OR ILLNESS RIGHT AFTER BIRTH? ☐ YES ☐ NO ☐ UNKNOWN

IF YES OR UNKNOWN, PLEASE EXPLAIN:

DID THE MOTHER EXPERIENCE COMPLICATIONS OR ILLNESS DURING OR RIGHT AFTER BIRTH? ☐ YES ☐ NO ☐ UNKNOWN

IF YES OR UNKNOWN, PLEASE EXPLAIN:

INITIAL FEEDING: ☐ BREAST ☐ BOTTLE ☐ UNKNOWN

DID THE MOTHER SMOKE DURING HER PREGNANCY? ☐ NO ☐ YES ☐ UNKNOWN

DID THE MOTHER DRINK ALCOHOL DURING HER PREGNANCY? ☐ NO ☐ YES ☐ UNKNOWN

DID THE MOTHER TAKE MEDICATIONS OR NARCOTICS DURING HER PREGNANCY? ☐ YES ☐ NO ☐ UNKNOWN

IF YES OR UNKNOWN, PLEASE EXPLAIN:

DID THE CHILD GO HOME WITH THEIR MOTHER FROM THE HOSPITAL? ☐ YES ☐ NO ☐ UNKNOWN

IF NO OR UNKNOWN, PLEASE EXPLAIN:

DEVELOPMENTAL HISTORY

AT WHAT AGE (IN MONTHS) DID YOUR CHILD FIRST SIT UP?

AT WHAT AGE (IN MONTHS) DID YOUR CHILD FIRST EAT SOLID FOOD?

AT WHAT AGE (IN MONTHS) DID YOUR CHILD FIRST SPEAK?

AT WHAT AGE (IN MONTHS) DID YOUR CHILD FIRST WALK?

HAS YOUR CHILD EVER BEEN EVALUATED FOR OR DIAGNOSED WITH A DEVELOPMENTAL DELAY? ☐ NO ☐ YES – EXPLAIN:

IS YOUR CHILD ENROLLED IN SCHOOL? ☐ YES ☐ NO

IF ENROLLED IN SCHOOL, ARE THEY DOING WELL? ☐ YES ☐ NO COMMENT:

IS YOUR CHILD IN A SPECIAL RESOURCE CLASS? ☐ YES ☐ NO

HAS YOUR CHILD FAILED OR REPEATED A GRADE? ☐ YES ☐ NO

HAS YOUR CHILD BEEN DIAGNOSED WITH A LEARNING DISABILITY? ☐ YES ☐ NO

COMMENTS

PEDIATRIC INFORMATION

Skip This Section

PARENTS, FAMILY & CAREGIVERS IN REGULAR CONTACT WITH YOUR CHILD

NAME	DATE OF BIRTH MM/DD/YYYY	RELATIONSHIP TO CHILD	CHECK IF SAME HOUSEHOLD
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

COMMENTS

LIVING SITUATION

PARENTS' MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ UNMARRIED, COHABITATING ☐ UNMARRIED, LIVING APART ☐ OTHER:

IF THE CHILD'S MOTHER AND FATHER DO NOT LIVE TOGETHER, OR IF THE CHILD DOES NOT LIVE WITH THEIR PARENTS, WHAT IS THEIR CUSTODY STATUS?

MOTHER'S OCCUPATION

FATHER'S OCCUPATION

WHERE IS THE CHILD DURING THE DAY? ☐ HOME ☐ DAYCARE ☐ SCHOOL ☐ OTHER:

DOES ANYONE IN THE HOUSEHOLD SMOKE? ☐ YES ☐ NO

DOES ANYONE AT DAYCARE SMOKE? ☐ YES ☐ NO

ARE THERE PETS IN THE HOME? ☐ YES ☐ NO

ARE THERE PETS AT DAYCARE? ☐ YES ☐ NO

ARE THERE FIREARMS IN THE HOME? ☐ NO ☐ YES – HIDDEN WITH GUN LOCKS ☐ YES – HIDDEN WITHOUT GUN LOCKS ☐ YES – KEPT IN A SAFE OR LOCKED CABINET ☐ YES – OTHER:

COMMENTS

SYMPTOMS

GENERAL	Now	Past
Chills	☐	☐
Dizziness/Light-Headedness	☐	☐
Fainting	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Night Sweats	☐	☐
Weakness	☐	☐

SKIN	Now	Past
Color Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Nail Changes	☐	☐
Rashes	☐	☐
Sores	☐	☐

HEAD & NECK	Now	Past
Bumps	☐	☐
Concussion	☐	☐
Headaches	☐	☐
Lumps	☐	☐
Masses	☐	☐
Migraines	☐	☐
Moles	☐	☐
Pain	☐	☐
Stiffness	☐	☐
Swelling	☐	☐

EYES	Now	Past
Black Spots/Floaters	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Dry and/or Itchy Eyes	☐	☐
Puffiness and/or Swelling	☐	☐
Red Eyes	☐	☐
Sticky and/or Crusty Eyes	☐	☐
Stye *(e.g. Red Bump on Eyelid)*	☐	☐
Watery Eyes	☐	☐

EARS	Now	Past
Deafness	☐	☐
Discharge	☐	☐
Dizziness	☐	☐
Ear Aches	☐	☐
Fluid	☐	☐
Itching	☐	☐
Loss of Hearing	☐	☐
Ringing	☐	☐
Room Spins	☐	☐

NOSE	Now	Past
Bleeding	☐	☐
Deviated Septum	☐	☐
Discharge	☐	☐
Loss of Smell	☐	☐
Obstruction	☐	☐
Pain	☐	☐
Post Nasal Drip	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐

MOUTH	Now	Past
Bad Breath	☐	☐
Bleeding Gums	☐	☐
Blisters	☐	☐
Cold Sores	☐	☐
Dental Problems	☐	☐
Dry Mouth	☐	☐
Loss of Taste	☐	☐
Sores	☐	☐
Ulcers	☐	☐

THROAT	Now	Past
Difficulty Swallowing	☐	☐
Hoarseness	☐	☐
Inflammation	☐	☐
Pain	☐	☐
Recurrent Infections	☐	☐
Soreness	☐	☐

LUNGS	Now	Past
Blood	☐	☐
Congestion	☐	☐
Cough	☐	☐
Inhalant Exposure	☐	☐
Pain	☐	☐
Phlegm	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

HEART	Now	Past
Blood Clots	☐	☐
Blue Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Cold Extremities	☐	☐
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Varicose Veins	☐	☐

GASTROINTESTINAL	Now	Past
Abdominal Pain	☐	☐
Belching	☐	☐
Black Stools	☐	☐
Bloating	☐	☐
Bloody Stools	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Food Intolerance	☐	☐
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowels	☐	☐
Hemorrhoids	☐	☐
Loss of Appetite	☐	☐
Nausea	☐	☐

SYMPTOMS *(Continued)*

NEUROLOGICAL	Now	Past
Anxiety	☐	☐
Difficulty Speaking	☐	☐
Dizziness	☐	☐
Loss of Facial Coordination	☐	☐
Loss of Muscle Coordination	☐	☐
Loss of Memory	☐	☐
Loss of Sensation/Touch	☐	☐
Numbness	☐	☐
Paralysis	☐	☐
Seizures	☐	☐
Tingling	☐	☐
Trembling Hands	☐	☐
Vertigo	☐	☐
Weak Grip	☐	☐

URINARY	Now	Past
Back Pain	☐	☐
Bed Wetting	☐	☐
Burning Sensation	☐	☐
Cloudy Urine	☐	☐
Discharge	☐	☐
Dribbling	☐	☐
Frequent Urination	☐	☐
Incontinence	☐	☐
Impotence	☐	☐
Painful Urination	☐	☐
Red/Pink/Discolored Ejaculate	☐	☐
Red/Pink/Discolored Urine	☐	☐
Small/Weak Stream	☐	☐
Stones	☐	☐
Straining	☐	☐
Urgency	☐	☐

COMMENTS

ENDOCRINE	Now	Past
Breast Changes	☐	☐
Dry Mouth	☐	☐
Frequent Urination	☐	☐
Hair Changes	☐	☐
Temperature Intolerance – Cold	☐	☐
Temperature Intolerance – Heat	☐	☐
Unexpected Fatigue	☐	☐
Unexpected Weight Gain	☐	☐
Unexpected Weight Loss	☐	☐
Last Prostate Exam		

PSYCHIATRIC	Now	Past
Alcoholism	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Drug Addiction	☐	☐
Drug Dependence	☐	☐
Extreme Worry	☐	☐
Hallucinations	☐	☐
Helplessness	☐	☐
Hyperactivity	☐	☐
Indecisiveness	☐	☐
Insecurity	☐	☐
Loss of Memory	☐	☐
Loss of Sensation/Touch	☐	☐
Panic Attacks	☐	☐
Sexual Difficulty	☐	☐
Social Anxiety	☐	☐
Suicidal Thoughts/Ideation	☐	☐
Timidity	☐	☐
Trouble Focusing	☐	☐
Trouble Sleeping	☐	☐

BLOOD	Now	Past
Anemia	☐	☐
Easy Bleeding	☐	☐
Easy Bruising	☐	☐
Iron Deficiency	☐	☐
Painful Nodes	☐	☐
Red Spots	☐	☐
Sugar in Blood	☐	☐
Swollen Nodes	☐	☐

FEMALE REPRODUCTIVE	Now	Past
Discharge	☐	☐
Hot Flashes	☐	☐
Irregular Periods	☐	☐
Menstrual Cramps	☐	☐
Painful Intercourse	☐	☐
Spotting Between Periods	☐	☐
Vaginal Itchiness	☐	☐

Menstrual Flow LIGHT ☐ MEDIUM ☐ HEAVY ☐

Age at First Period

Contraception Type

Duration of Cycle

Duration of Flow

Last Mammogram

Last Pap Smear

Last Period

Last Vaginal Exam

No. of Abortions

No. of Births

No. of Miscarriages

No. of Pregnancies

PERSONAL MEDICAL HISTORY

Skip This Section

CONDITION *(Check All That Apply)*	DATE OF ONSET MM/DD/YYYY
☐ Autoimmune Disease	
☐ Arthritis	
☐ Asthma	
☐ Bronchitis	
☐ Cancer	
☐ Cataracts	
☐ Diabetes – Type 1	
☐ Diabetes – Type 2	
☐ Dizziness	
☐ Emphysema	
☐ Epilepsy	
☐ Fainting	
☐ Frequent and/or Severe Headache	
☐ Glaucoma	
☐ Gonorrhea	
☐ Gout	
☐ Human Immunodeficiency Virus (HIV)	
☐ Hearing Impairment	
☐ Heart Condition	
☐ Heart Disease	
☐ Hemodialysis	
☐ Herpes Simplex	

CONDITION *(Check All That Apply)*	DATE OF ONSET MM/DD/YYYY
☐ High Blood Cholesterol	
☐ High Blood Pressure	
☐ Hypoglycemia	
☐ Intellectual/Mental Disability	
☐ Jaundice	
☐ Kidney Disease	
☐ Low Blood Pressure	
☐ Pain or Pressure in Chest	
☐ Palpitations	
☐ Periods of Unconsciousness	
☐ Rheumatic Fever	
☐ Rheumatoid Arthritis	
☐ Seizures	
☐ Shortness of Breath	
☐ Stomach, Liver, or Intestinal Issues	
☐ Syphilis	
☐ Tuberculosis	
☐ Tumor *(Note Location in Comments)*	
☐ Thyroid Issues	
☐ Urinary Tract Infection	
☐ Vision Impairment	
☐ Other *(Please Explain in Comments)*	

COMMENTS

FAMILY MEDICAL HISTORY

Skip This Section

	MOTHER	FATHER	SIBLINGS	GRANDPARENTS	CHILDREN
Birth Year(s); If Deceased, Indicate Age and Cause of Death					
Alcoholism	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes (Type 1)	☐	☐	☐	☐	☐
Diabetes (Type 2)	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Heart Condition	☐	☐	☐	☐	☐
Hemodialysis	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
High Blood Cholesterol	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Intellectual/Mental Disability	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Smoking	☐	☐	☐	☐	☐
Stomach/Liver/Intestinal Issues	☐	☐	☐	☐	☐
Thyroid Disorders	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Tumor	☐	☐	☐	☐	☐
Other *(Explain in Comments)*	☐	☐	☐	☐	☐

COMMENTS

INFECTIOUS DISEASES

Skip This Section

CONDITION *(Check All That Apply)*	DATE OF ONSET MM/DD/YYYY	CONDITION *(Check All That Apply)*	DATE OF ONSET MM/DD/YYYY
☐ Chickenpox/Varicella		☐ Mumps	
☐ COVID-19/Coronavirus		☐ Pertussis/Whooping Cough	
☐ Ebola		☐ Pneumonia	
☐ Hepatitis A		☐ Polio	
☐ Hepatitis B		☐ Scarlet Fever	
☐ Hepatitis C		☐ West Nile Virus	
☐ Malaria		☐ Zika	
☐ Measles		☐ Other *(Explain in Comments)*	

COMMENTS

ALLERGIES/DRUG SENSITIVITIES

Skip This Section

ALLERGY/SENSITIVITY*	REACTION	DATE LAST OCCURRED	TREATMENT

**Include Medications, Foods, Environmental, or Other*

COMMENTS

IMMUNIZATIONS/VACCINATIONS

Skip This Section

IMMUNIZATION	INITIAL DOSE DATE MM/DD/YYYY	BOOSTER 1 DATE MM/DD/YYYY	BOOSTER 2 DATE MM/DD/YYYY	BOOSTER 3 DATE MM/DD/YYYY
☐ Chickenpox/Varicella				
☐ COVID-19/Coronavirus				
☐ Diptheria				
☐ Gardasil HPV				
☐ Haemophilis Influenza				
☐ Hepatitis A				
☐ Hepatitis B				
☐ Influenza/Annual Flu Shot				
☐ Influenza/Annual Flu Shot				
☐ Influenza/Annual Flu Shot				
☐ Influenza/Annual Flu Shot				
☐ Measles/Mumps/Rubella (MMR)				
☐ Meningitis A				
☐ Meningitis B				
☐ Pertussis/Whooping Cough				
☐ Polio				
☐ Rotavirus				
☐ Shingles				
☐ Smallpox				
☐ Tetanus				
☐ Typhoid				
☐ Yellow Fever				
☐ Other				

COMMENTS

DOCTOR VISITS

Skip This Section

VISIT DATE MM/DD/YYYY	DOCTOR NAME*	REASON FOR VISIT	DIAGNOSIS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

BLOOD WORK

Skip This Section

TEST DATE MM/DD/YYYY

CHOLESTEROL – HDL

CHOLESTEROL – LDL

CHOLESTEROL – TOTAL

LIPIDS – TOTAL

FASTING BLOOD SUGAR

HEMOGLOBIN A1C

OTHER:

OTHER:

OTHER:

OTHER:

OTHER:

OTHER:

OTHER:

OTHER:

OTHER:

OTHER:

OTHER:

COMMENTS

IMAGING *(e.g. MRI, CAT Scan, PET Scan)*

TEST #1

TEST DATE MM/DD/YYYY

TEST TYPE

REQUESTING DOCTOR*

ADMINISTERED BY *(i.e. Testing Facility)*

REASON FOR TEST

DIAGNOSIS

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

TEST #2

TEST DATE MM/DD/YYYY

TEST TYPE

REQUESTING DOCTOR*

ADMINISTERED BY *(i.e. Testing Facility)*

REASON FOR TEST

DIAGNOSIS

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

TEST #3

TEST DATE MM/DD/YYYY

TEST TYPE

REQUESTING DOCTOR*

ADMINISTERED BY *(i.e. Testing Facility)*

REASON FOR TEST

DIAGNOSIS

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

TEST #4

TEST DATE MM/DD/YYYY

TEST TYPE

REQUESTING DOCTOR*

ADMINISTERED BY *(i.e. Testing Facility)*

REASON FOR TEST

DIAGNOSIS

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

MAJOR HEALTH EVENTS *(e.g. Major Illnesses, Pregnancy & Childbirth, Surgeries)*

Skip This Section

MAJOR HEALTH EVENT 1

CONDITION

DATE DIAGNOSED MM/DD/YYYY

DOCTOR NAME

DOCTOR PHONE NUMBER

CONDITION STATUS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

MAJOR HEALTH EVENT 2

CONDITION

DATE DIAGNOSED MM/DD/YYYY

DOCTOR NAME

DOCTOR PHONE NUMBER

CONDITION STATUS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

MAJOR HEALTH EVENT 3

CONDITION

DATE DIAGNOSED MM/DD/YYYY

DOCTOR NAME

DOCTOR PHONE NUMBER

CONDITION STATUS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

MAJOR HEALTH EVENT 4

CONDITION

DATE DIAGNOSED MM/DD/YYYY

DOCTOR NAME

DOCTOR PHONE NUMBER

CONDITION STATUS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

MAJOR HEALTH EVENTS *(Continued)*

Skip This Section

MAJOR HEALTH EVENT 5

CONDITION

DATE DIAGNOSED MM/DD/YYYY

DOCTOR NAME

DOCTOR PHONE NUMBER

CONDITION STATUS

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

MAJOR HEALTH EVENT 6

CONDITION

DATE DIAGNOSED MM/DD/YYYY

DOCTOR NAME

DOCTOR PHONE NUMBER

CONDITION STATUS

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

LIFESTYLE

Skip This Section

EXERCISE

TYPE OF EXERCISE

FREQUENCY *(i.e. Times per Week or Month)*

TYPE OF EXERCISE

FREQUENCY *(i.e. Times per Week or Month)*

TYPE OF EXERCISE

FREQUENCY *(i.e. Times per Week or Month)*

COMMENTS

TOBACCO, ALCOHOL & NARCOTIC USE

ALCOHOL – DO YOU DRINK ALCOHOL CURRENTLY OR IN THE PAST?

FREQUENCY *(i.e. Drinks per Week)*

YEAR STARTED

YEAR ENDED

TOBACCO – DO YOU SMOKE AND/OR CHEW TOBACCO CURRENTLY OR IN THE PAST?

FREQUENCY *(i.e. Drinks per Week)*

YEAR STARTED

YEAR ENDED

NARCOTICS – DO YOU USE RECREATIONAL NARCOTICS CURRENTLY OR IN THE PAST?

FREQUENCY *(i.e. Drinks per Week)*

YEAR STARTED

YEAR ENDED

COMMENTS

DURABLE MEDICAL EQUIPMENT

Skip This Section

DURABLE MEDICAL DEVICE 1

DEVICE TYPE *(e.g. Glucose Monitor, Insulin Pump, Pacemaker)*

RELEVANT MEDICAL CONDITION

DEVICE MANUFACTURER

DEVICE MODEL

DATE OF FIRST USE MM/DD/YYYY

PRESCRIBING DOCTOR NAME*

PRESCRIBING DOCTOR HOSPITAL/CLINIC

PRESCRIBING DOCTOR PHONE NUMBER

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

DURABLE MEDICAL DEVICE 2

DEVICE TYPE *(e.g. Glucose Monitor, Insulin Pump, Pacemaker)*

RELEVANT MEDICAL CONDITION

DEVICE MANUFACTURER

DEVICE MODEL

DATE OF FIRST USE MM/DD/YYYY

PRESCRIBING DOCTOR NAME*

PRESCRIBING DOCTOR HOSPITAL/CLINIC

PRESCRIBING DOCTOR PHONE NUMBER

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

DURABLE MEDICAL DEVICE 3

DEVICE TYPE *(e.g. Glucose Monitor, Insulin Pump, Pacemaker)*

RELEVANT MEDICAL CONDITION

DEVICE MANUFACTURER

DEVICE MODEL

DATE OF FIRST USE MM/DD/YYYY

PRESCRIBING DOCTOR NAME*

PRESCRIBING DOCTOR HOSPITAL/CLINIC

PRESCRIBING DOCTOR PHONE NUMBER

COMMENTS

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

PHYSICAL/OCCUPATIONAL THERAPY

Skip This Section

PHYSICAL/OCCUPATIONAL THERAPY 1

PHYSICAL THERAPY TYPE *(e.g. Cardiovascular, Geriatric, Neurological, Orthopedic, Pediatric)*

RELEVANT MEDICAL CONDITION AND/OR EVENT

FREQUENCY *(i.e. Therapy Sessions per Month)*

THERAPY START DATE MM/DD/YYYY

THERAPY END DATE MM/DD/YYYY

PHYSICAL THERAPIST NAME*

PHYSICAL THERAPIST HOSPITAL/CLINIC

PHYSICAL THERAPIST PHONE NUMBER

COMMENTS

**If Available, Please Add This Clinician's Credentials to Your Healthcare Providers.*

PHYSICAL/OCCUPATIONAL THERAPY 2

PHYSICAL THERAPY TYPE *(e.g. Cardiovascular, Geriatric, Neurological, Orthopedic, Pediatric)*

RELEVANT MEDICAL CONDITION AND/OR EVENT

FREQUENCY *(i.e. Therapy Sessions per Month)*

THERAPY START DATE MM/DD/YYYY

THERAPY END DATE MM/DD/YYYY

PHYSICAL THERAPIST NAME*

PHYSICAL THERAPIST HOSPITAL/CLINIC

PHYSICAL THERAPIST PHONE NUMBER

COMMENTS

**If Available, Please Add This Clinician's Credentials to Your Healthcare Providers.*

PHYSICAL/OCCUPATIONAL THERAPY 3

PHYSICAL THERAPY TYPE *(e.g. Cardiovascular, Geriatric, Neurological, Orthopedic, Pediatric)*

RELEVANT MEDICAL CONDITION AND/OR EVENT

FREQUENCY *(i.e. Therapy Sessions per Month)*

THERAPY START DATE MM/DD/YYYY

THERAPY END DATE MM/DD/YYYY

PHYSICAL THERAPIST NAME*

PHYSICAL THERAPIST HOSPITAL/CLINIC

PHYSICAL THERAPIST PHONE NUMBER

COMMENTS

**If Available, Please Add This Clinician's Credentials to Your Healthcare Providers.*

VISION EXAMS

Skip This Section

VISION EXAM 1

DATE OF EXAM MM/DD/YYYY

VISION RX

DOCTOR NAME*

DOCTOR HOSPITAL/CLINIC

DOCTOR PHONE NUMBER

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

VISION EXAM 2

DATE OF EXAM MM/DD/YYYY

VISION RX

DOCTOR NAME*

DOCTOR HOSPITAL/CLINIC

DOCTOR PHONE NUMBER

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

VISION EXAM 3

DATE OF EXAM MM/DD/YYYY

VISION RX

DOCTOR NAME*

DOCTOR HOSPITAL/CLINIC

DOCTOR PHONE NUMBER

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

VISION EXAM 4

DATE OF EXAM MM/DD/YYYY

VISION RX

DOCTOR NAME*

DOCTOR HOSPITAL/CLINIC

DOCTOR PHONE NUMBER

**If Available, Please Add This Doctor's Credentials to Your Healthcare Providers.*

COMMENTS

PRIMARY DENTAL HEALTH PROVIDER

LAST NAME

FIRST NAME

PROVIDER TYPE

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL DENTAL HEALTH PROVIDER

Skip This Section

LAST NAME

FIRST NAME

PROVIDER TYPE

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL DENTAL HEALTH PROVIDER

Skip This Section

LAST NAME

FIRST NAME

PROVIDER TYPE

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

ADDITIONAL DENTAL HEALTH PROVIDER

Skip This Section

LAST NAME

FIRST NAME

PROVIDER TYPE

GROUP OR ASSOCIATION NAME

STREET ADDRESS 1

STREET ADDRESS 2

BUILDING/SUITE/UNIT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE NUMBER

ALTERNATE PHONE NUMBER

FAX NUMBER

EMAIL ADDRESS

COMMENTS

DENTAL PROFILE

Skip This Section

UPPER LEFT

1. THIRD MOLAR *(Wisdom Tooth)*
2. SECOND MOLAR *(Twelve-Year Molar)*
3. FIRST MOLAR *(Six-Year Molar)*
4. SECOND BICUSPID *(Second Pre-Molar)*
5. FIRST BICUSPID *(First Pre-Molar)*
6. CUSPID *(Canine/Eye Tooth)*
7. LATERAL INCISOR
8. CENTRAL INCISOR

UPPER RIGHT

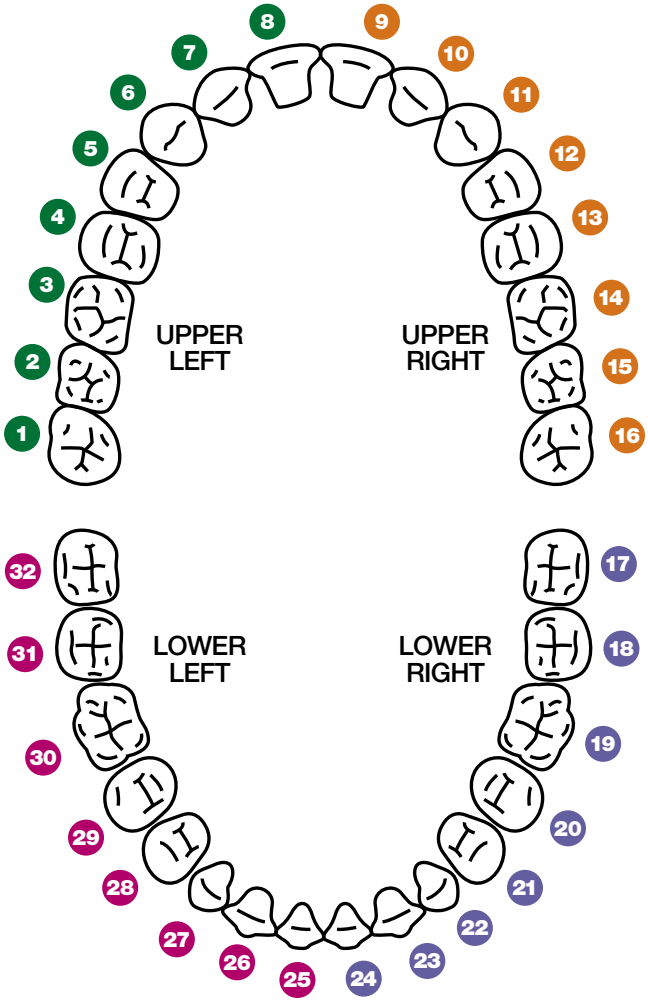
9. CENTRAL INCISOR
10. LATERAL INCISOR
11. CUSPID *(Canine/Eye Tooth)*
12. FIRST BICUSPID *(First Pre-Molar)*
13. SECOND BICUSPID *(Second Pre-Molar)*
14. FIRST MOLAR *(Six-Year Molar)*
15. SECOND MOLAR *(Twelve-Year Molar)*
16. THIRD MOLAR *(Wisdom Tooth)*

LOWER RIGHT

17. THIRD MOLAR *(Wisdom Tooth)*
18. SECOND MOLAR *(Twelve-Year Molar)*
19. FIRST MOLAR *(Six-Year Molar)*
20. SECOND BICUSPID *(Second Pre-Molar)*
21. FIRST BICUSPID *(First Pre-Molar)*
22. CUSPID *(Canine/Eye Tooth)*
23. LATERAL INCISOR
24. CENTRAL INCISOR

LOWER LEFT

25. CENTRAL INCISOR
26. LATERAL INCISOR
27. CUSPID *(Canine/Eye Tooth)*
28. FIRST BICUSPID *(First Pre-Molar)*
29. SECOND BICUSPID *(Second Pre-Molar)*
30. FIRST MOLAR *(Six-Year Molar)*
31. SECOND MOLAR *(Twelve-Year Molar)*
32. THIRD MOLAR *(Wisdom Tooth)*



LEGEND

A	Untouched	ONL	Onlay
1F, 2F, 3F	1, 2, 3 Fillings	PLD	Partial Lower Denture
BRDG	Bridge	PUD	Partial Upper Denture
CRN	Crown	X	Pulled/Removed
IMP	Implant	RC	Root Canal
INL	Inlay	VN	Veneer

☐ COMPLETE UPPER DENTURES ☐ COMPLETE LOWER DENTURES

COMMENTS

MAJOR DENTAL HEALTH EVENTS *(e.g. Injuries, Root Canal)*

Skip This Section

MAJOR DENTAL HEALTH EVENT 1

CONDITION/DIAGNOSIS

DATE DIAGNOSED MM/DD/YYYY

CONDITION STATUS

DOCTOR NAME*

DOCTOR GROUP OR ASSOCIATION NAME

DOCTOR PHONE NUMBER

COMMENTS

**If Available, Please Add This Dentist's Credentials to Dental Health Providers.*

MAJOR DENTAL HEALTH EVENT 2

CONDITION/DIAGNOSIS

DATE DIAGNOSED MM/DD/YYY

CONDITION STATUS

DOCTOR NAME*

DOCTOR GROUP OR ASSOCIATION NAME

DOCTOR PHONE NUMBER

COMMENTS

**If Available, Please Add This Dentist's Credentials to Dental Health Providers.*

MAJOR DENTAL HEALTH EVENT 3

CONDITION/DIAGNOSIS

DATE DIAGNOSED MM/DD/YYYY

CONDITION STATUS

DOCTOR NAME*

DOCTOR GROUP OR ASSOCIATION NAME

DOCTOR PHONE NUMBER

COMMENTS

**If Available, Please Add This Dentist's Credentials to Dental Health Providers.*

MAJOR DENTAL HEALTH EVENTS *(e.g. Injuries, Root Canal)*

Skip This Section

MAJOR DENTAL HEALTH EVENT 4

CONDITION/DIAGNOSIS

DATE DIAGNOSED MM/DD/YYYY

CONDITION STATUS

DOCTOR NAME*

DOCTOR GROUP OR ASSOCIATION NAME

DOCTOR PHONE NUMBER

**If Available, Please Add This Dentist's Credentials to Dental Health Providers.*

COMMENTS

MAJOR DENTAL HEALTH EVENT 5

CONDITION/DIAGNOSIS

DATE DIAGNOSED MM/DD/YYYY

CONDITION STATUS

DOCTOR NAME*

DOCTOR GROUP OR ASSOCIATION NAME

DOCTOR PHONE NUMBER

**If Available, Please Add This Dentist's Credentials to Dental Health Providers.*

COMMENTS

MAJOR DENTAL HEALTH EVENT 6

CONDITION/DIAGNOSIS

DATE DIAGNOSED MM/DD/YYYY

CONDITION STATUS

DOCTOR NAME*

DOCTOR GROUP OR ASSOCIATION NAME

DOCTOR PHONE NUMBER

**If Available, Please Add This Dentist's Credentials to Dental Health Providers.*

COMMENTS

LIVING WILL

Skip This Section

Declaration made this Month Day Year , I, , willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and (initial) I have a terminal condition, or (initial) I have an end-stage condition, or (initial) I am in a persistent vegetative state, and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

- ☐ Yes; I do want to receive nutritional support
- ☐ No; I do not want to receive nutritional support
- ☐ Yes; I do want to receive hydration
- ☐ No; I do not want to receive hydration
- ☐ Yes; I do want to receive pain relieving medication to ease any and all discomfort

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

LAST NAME LAST NAME

STREET ADDRESS BUILDING/SUITE/UNIT NUMBER

CITY STATE ZIP CODE

PHONE NUMBER EMAIL ADDRESS

Name: **SIGNED:** my checking the box and dating will suffice as my handwritten signature ☐ Month Day Year

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

WITNESS WITNESS

PHONE NUMBER EMAIL ADDRESS PHONE NUMBER EMAIL ADDRESS

At least one witness must not be a husband or wife or a blood relative of the principal.

ADDITIONAL INSTRUCTIONS (OPTIONAL):

If a legal document already exist, it can be found at:

NAME PHONE NUMBER EMAIL ADDRESS

STREET ADDRESS CITY STATE ZIP CODE

LEGAL DOCUMENTS DESIGNATION OF HEALTH CARE SURROGATE

Skip This Section

FIRST NAME LAST NAME

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and Surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

LAST NAME FIRST NAME

STREET ADDRESS BUILDING/SUITE/UNIT NUMBER

CITY STATE ZIP CODE

PHONE NUMBER EMAIL ADDRESS

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

LAST NAME FIRST NAME

STREET ADDRESS APARTMENT/SUITE/UNIT NUMBER

CITY STATE ZIP CODE

PHONE NUMBER EMAIL ADDRESS

Fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.
I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

NAME PHONE NUMBER EMAIL ADDRESS

NAME PHONE NUMBER EMAIL ADDRESS

If a legal document already exist, it can be found at:

NAME PHONE NUMBER EMAIL ADDRESS

STREET ADDRESS CITY STATE ZIP CODE

Name:

SIGNED: my checking the box and dating will suffice as my handwritten signature ☐ Month Day Year