

HEALTH INFORMATION

H.I. Doc.

Health Information Document

HEALTH INFORMATION

Your Health Information



PERSONAL 1

Your Name: _____

Date of Birth: _____

Phone (home): _____

Phone (cell/work): _____

Email: _____

Parent/Guardian's Name: _____

Phone (cell/work): _____

Email: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Insurance Company: _____

ID #: _____

Group #: _____

Main Diagnosis: _____

Other Diagnoses or Major Injuries: _____

YOUR SPECIAL CARE NEEDS 2

Your Allergies: Include medicine, food, environment, contact, or other. Also describe what happens.

1. _____

What happens: _____

2. _____

What happens: _____

3. _____

What happens: _____

Your main language, or way to communicate: _____

Describe any challenges you have with movement, hearing, eyesight, or thinking: _____

Special safety instructions, crisis plans, or hotline phone #: _____

Special conditions, treatment challenges, unusual findings, or equipment used (type and size): _____

YOUR USUAL DOCTOR 3

Doctor: _____

Address: _____

(See back page for specialists and other providers)

Phone: _____

Email: _____

Fax: _____

Hospital used most often: _____

Phone: _____

Specialty hospital: _____

Phone: _____

Pharmacy Name: _____

Phone: _____

Major Surgeries and Hospitalizations:

Where: _____

Why: _____

Date: _____

Where: _____

Why: _____

Date: _____

Where: _____

Why: _____

Date: _____

Where: _____

Why: _____

Date: _____

Where: _____

Why: _____

Date: _____

YOUR MEDICINE 4

Name of Medicine	For what reason	Amount (Dose) and how often	Doctor who ordered

MEDICINES TRIED 5

Medicines tried in the past that didn't work and what happened:

(Over)

HEALTH INFORMATION

Fill out this card and carry it with you.

To get a new card, call the NYS Department of Health at: **1-518-473-9883** or visit: **www.nyhealth.gov/community/special_needs**



HEALTH INFORMATION

Your Health Information (continued)

Your Name: _____

OTHER PROVIDERS 6

Other Health Care Providers (for example, doctors, specialists, dentists, therapists, etc.)

Name: _____	Reason: _____	Phone: _____
Name: _____	Reason: _____	Phone: _____
Name: _____	Reason: _____	Phone: _____
Name: _____	Reason: _____	Phone: _____
Name: _____	Reason: _____	Phone: _____

Other Care Providers

School Contact: _____	Phone: _____	Email: _____
Therapist: _____	Phone: _____	Email: _____
Other: _____	Phone: _____	Email: _____

IMMUNIZATIONS 7

Immunizations (Shots)	Date	Date	Date	Date	Date
Diphtheria, Pertussis, Tetanus (DPT/DTaP)					
Tetanus, Diphtheria, acellular pertussis (Tdap)					
Tetanus (Td)					
Polio					
Measles, Mumps, Rubella (MMR)					
Varicella (Chickenpox)					
Hib (Haemophilus influenzae type b)					
Pneumococcal (PCV)					
Meningococcal					
Hepatitis B					
Hepatitis A					
Human Papillomavirus (HPV)					
Tuberculosis (Mantoux or PPD)					
Influenza (Flu)					
Other					

TESTS 8

Tests	Date	Results	Date	Results	Date	Results

OTHER 9

Anything you'd like to add? _____

INFO SHARING 10

Which family members, guardians, or other people are allowed to discuss your medical information with your doctor? (If you're 18 years of age or older, you'll need to include them on the "HIPAA" privacy form your doctor gives you.)

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

Keep this card up-to-date. You are responsible for the accuracy of this information.