

# Health Information Form *for Adults*



## IDENTIFICATION

Name			
Address			
City	State	Zip	
Home Phone	Work Phone		
Date of Birth	Male	Female	
Height	Weight	Eye Color	Blood / RH Type
Languages Spoken			
Primary Health Insurance Carrier		Policy Number	
Secondary Health Insurance Carrier		Policy Number	
Languages Spoken			

### *In Case of Emergency Notify:*

Name		
Relationship	Phone	
Address		
City	State	Zip
Home Phone	Work Phone	
Physician ( <i>Indicate Specialty</i> )	Phone	
Dentist	Phone	
Pharmacy	Phone	

## MEDICAL HISTORY *check appropriate items*

Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive:		Tumor	
Arthritis		Hypoglycemia	
Asthma		Fainting	
Cancer		Seizures	
Diabetes		Glaucoma	
Dizziness		Low Blood Pressure	
Epilepsy		Mental Retardation	
Eye Problem		Pain or Pressure in Chest	
Frequent or Severe Headache		Palpitations	
Hearing Impairment		Periods of Unconsciousness	
Heart Condition		Rheumatic Fever	
High Blood Cholesterol		Shortness of Breath	
High Blood Pressure		Smoking / packs per day:      number of years:	
Jaundice		Stomach, Liver or Intestinal Problems	
Hepatitis		Thyroid Problems	
Kidney Disease		Tuberculosis	
Hemodialysis		Urinary Tract Infection	
Rheumatism		Sexually Transmitted Diseases	
Bronchitis		Chlamydia:      Herpes:      Gonorrhea:      Syphilis:	
Emphysema		Other	





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**INFECTIOUS DISEASES**

Disease	Age	Date	Remarks
Chickenpox			
Measles			
Rubella			
Hepatitis			
Mumps			
Polio			
Pneumonia			
Pertussis / Whooping Cough			
Scarlet Fever			
Other			

**IMMUNIZATIONS**

Immunization for	Age	Date	BOOSTER 1		BOOSTER 2		BOOSTER 3	
			Age	Date	Age	Date	Age	Date
Diphtheria								
Pertussis / Whooping Cough								
Tetanus								
Polio								
Smallpox								
Typhoid								
Rubella								
Mumps								
Measles								
Tuberculosis								
Hepatitis B								
Other								