HEALTH INFORMATION

H.I. Doc.

Health Information Document

HEALTH INFORMATION

Your Health Information

1 PERSONAL

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: _____

2 YOUR SPECIAL CARE NEEDS

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): _____

_____

3 YOUR USUAL DOCTOR

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: _____

4 YOUR MEDICINE

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

5 MEDICINES TRIED

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: **1-518-474-2001,** or visit: **www.nyhealth.gov/community/special_needs**

HEALTH INFORMATION

Your Health Information (continued)

Your Name: _____

6 OTHER PROVIDERS

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: _____

7 IMMUNIZATIONS

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					

8 TESTS

Tests	Date	Results	Date	Results	Date	Results

9 OTHER

Anything you'd like to add? _____

_____

_____

10 INFO SHARING

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.

STATE OF NEW YORK
DEPARTMENT OF HEALTH