

Are You Prepared? **Personal Health Information**

Your Contact Information

NAME: _____

Date of Birth: ___/___/___ Male ___ Female ___ Date last updated (aim to update form every year): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-mail: _____

Parent/Guardian/Other Support Person: _____

Phone Number/Other Contact Information: _____

Relationship: _____

Your Health Care Providers

Primary Care Physician: _____

Location: _____ Phone Number: _____

Specialist Physician/Other Health Care Provider: _____

Location: _____ Phone Number: _____

Specialist Physician/Other Health Care Provider: _____

Location: _____ Phone Number: _____

Dentist: _____

Location: _____ Phone Number: _____

Preferred Pharmacy: _____

Location: _____ Phone Number: _____

Your Insurance

Employer: _____

Insurance Provider (attach copies of insurance cards): _____

Policy Number: _____ Phone Number: _____

Dental Insurance Provider: _____

Policy Number: _____ Phone Number: _____

Pharmacy Insurance Provider: _____

Policy Number: _____ Phone Number: _____

Your Medications

Active Medications and Prescription Information (attach copies of all active prescriptions):

Medication: _____

Prescription Number: _____

Instructions/Dosage: _____

Medication: _____

Prescription Number: _____

Instructions/Dosage: _____

Glasses _____ **Contact lenses** _____

Prescription: _____

Brand (contact lenses): _____

Your Health History

Medical Conditions: _____

Blood Type: _____

Allergies: _____

Diet Restrictions: _____

Immunizations (attach copies of immunization records, including dates): _____

Recent Laboratory Results (for example, blood tests and results of mammograms and pap smears): _____

Recent Hospitalizations (include dates): _____

Recent Surgeries (include dates): _____

Your Pet's Health

Veterinarian: _____ **Phone Number:** _____

Immunizations (attach copies of immunization records): _____

Other Pet Health Information: _____