

Health Information Form-*for Adults*



**PALO ALTO COUNTY
HEALTH SYSTEM**

AFFILIATED WITH
MERCY HEALTH NETWORK

A. Identification

B. Emergency Contacts

Name (Last) (First) (Middle)				In Case of Emergency, Notify: Primary Contact			
Maiden Name				Name (last) (First) (Middle)			
Primary Address				Relationship			
City	State	Zip	Country	Address			
Alternate Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Home Phone		Work Phone	
Home Phone		Work Phone		Cell Phone		Email Address	
Cell Phone		Email Address					
Date of Birth		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		In Case of Emergency, Notify: Secondary Contact			
Height	Weight	Eye Color	Hair Color	Name (last)	Name (middle)	Name (first)	
Race	Birthmark/Scars			Relationship			
Blood/RH Type	Special Conditions	Marital Status		Address			
Occupation				City	State	Zip Code	Country
Company Name				Home Phone		Work Phone	
City	State	Zip Code	Country	Cell Phone		Email Address	
Phone Number		Languages Spoken		In Case of Emergency, Notify: Medical Contact			
Primary Health Insurance Carrier		Policy Number		Doctor (<i>Indicate Specialty</i>)			
Secondary Health Insurance Carrier		Policy Number					
				Phone Number			
				Dentist		Telephone Number	
				Pharmacy		Telephone Number	

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C. Healthcare Provider

Healthcare Provider Specialty	Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City	State	Zip Code	Country

Healthcare Provider Specialty	Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City	State	Zip Code	Country

Healthcare Provider Specialty	Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City	State	Zip Code	Country

Healthcare Provider Specialty	Primary Care Physician <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City	State	Zip Code	Country

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D. Insurance Providers

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/ URL			
Address				Primary Insured Person-Name		Social Security No.	
City	State	Zip Code	Country	Name of Employer			
Contact - Name		Phone		Address			
Identification-Group Number		Member(ID) Number		City	State	Zip Code	Country
Contact Information-Phone		Emergency Phone No.(after hours)		Phone Number			

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/ URL			
Address				Primary Insured Person-Name		Social Security No.	
City	State	Zip Code	Country	Name of Employer			
Contact-Name		Phone		Address			
Identification-Group Number		Member(ID) Number		City	State	Zip Code	Country
Contact Information-Phone		Emergency Phone No.(after hours)		Phone Number			

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/ URL			
Address				Primary Insured Person-Name		Social Security No.	
City	State	Zip Code	Country	Name of Employer			
Contact-Name		Phone		Address			
Identification-Group Number		Member(ID) Number		City	State	Zip Code	Country
Contact Information-Phone		Emergency Phone No.(after hours)		Phone Number			

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E. Legal Documents/Medical Directives

<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare <input type="checkbox"/> Power of Attorney				Fax			
Document Location (Physical Location)				Contact (Name of person who has access to the document)			
Location Name (for example Bank of America)				Address			
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			
Legal Representative (Name of person who you have assigned legal authority)				Home Phone		Cellular Phone	
Address				Pager		E-mail Address	
City	State	Zip Code	Country	Work Phone		Work E-mail Address	
Contact Information				Fax			
Home Phone		Cellular Phone		Date Filed			
Pager		E-mail Address		Organ Donation:			
Work E-mail Address		Work Phone		Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No		State Where Registered	

<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare <input type="checkbox"/> Power of Attorney				Fax			
Document Location(Physical Location)				Contact (Name of person who has access to the document)			
Location Name (for example Bank of America)				Address			
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			
Legal Representative (Name of person who you have assigned legal authority)				Home Phone		Cellular Phone	
Address				Pager		E-mail Address	
City	State	Zip Code	Country	Work Phone		Work E-mail Address	
Contact Information				Fax			
Home Phone		Cellular Phone		Date Filed			
Pager		E-mail Address		Organ Donation:			
Work E-mail Address		Work Phone		Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No		State Where Registered	

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F. Medical History (Check appropriate)

	Date of Onset		Date of Onset
<input type="checkbox"/> Acquired Immunodeficiency Syndrome(AIDS) or HIV Positive:		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Hypoglycemia	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Chlamydia		<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Pain or Pressure in Chest	
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Palpitations	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Periods of unconsciousness	
<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Eye Problem		<input type="checkbox"/> Rheumatism	
<input type="checkbox"/> Fainting		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Frequent or Severe Headaches		<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Stomach Liver or Intestinal Problems	
<input type="checkbox"/> Gonorrhea		<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Hearing Impairment		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Heart Condition		<input type="checkbox"/> Tumor	
<input type="checkbox"/> Hemodialysis		<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Herpes		<input type="checkbox"/> Urinary Tract Infection	
<input type="checkbox"/> High Blood Cholesterol		<input type="checkbox"/> Other	

G. Infectious Diseases

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

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J. Family Member History

	Mother	Father	Sibling(s)	Grandparent(s)	Children
Enter ages of relatives					
If deceased, indicate age and cause of death					
Check all items that apply for their present state of health or any illnesses they have had					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
Hemodialysis					
Hepatitis					
High Blood Cholesterol					
High Blood Pressure					
Kidney Disease					
Mental Retardation					
Rheumatic Fever					
Seizures					
Smoking					
Stomach Liver or Intestinal Problems					
Stroke					
Thyroid Disorders					
Tuberculosis					
Tumor					
Other					

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O. Hospitalizations

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Admission Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	Admission Date
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	Admission Date
Doctor		
Hospital		
Reason		Complications

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P. Surgeries

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

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Q. Lab or Imaging (Examples: X-ray, MRI, Mammogram)

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

R. Medical Devices (Examples: pacemaker, insulin pumas, breathing devices)

Device Type	Doctor	Device Type	Doctor
Hospital	Date	Hospital	Date
Reason		Reason	

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S.Physical/Occupation Therapy

Therapy Type	Start Date	Stop Date	Frequency	Therapist

T. VISION

Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	
Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	

U. Dental Health

Date of Visit	Dentist	Problems	Resolution

If You Don't Take Time For Your Health Today....
 You Will **HAVE** To Make Time For Your Illness Tomorrow