



# Health Care Information

## PERSONAL INFORMATION

First Name	(Nickname)	Last Name	DOB or Age
Street Address		City, State, ZIP	
Preferred Language	Phone Number	Emergency Contact Information	
Parent/Legal Representative		Parent/Legal Representative Phone/Email	
Insurance Information		Pharmacy Information (most commonly used)	
Primary Care Provider/Contact Information		Specialty Care Providers/Contact Information	
Communication Support Needed			

## Current Symptoms

Symptom	When it started
<input type="checkbox"/> Fever - Temp:	
<input type="checkbox"/> Cough	
<input type="checkbox"/> Muscle Pain/Fatigue	
<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Chest Pain/Pressure	
<input type="checkbox"/> Blue Lips/Face	
<input type="checkbox"/> Nasal Congestion	
<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Loss of Smell/Taste	
<input type="checkbox"/> Sore Throat	
<input type="checkbox"/> Blood Oxygen <90	
<input type="checkbox"/> Headache	
<input type="checkbox"/> Confusion/Won't Wake	
<input type="checkbox"/> Body Ache	
<input type="checkbox"/> Chills/Shaking with Chills	
<input type="checkbox"/> Other:	

Note: Information on this form may not be complete

## Medication List

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## Allergies and Dietary Restrictions

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## Medical/Assistive Devices and/or Service Animal

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## Check all that apply

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Neurodevelopmental disorder/ID | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Immunocompromised        | <input type="checkbox"/> Smoker                  |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Severe obesity (>40 BMI) | <input type="checkbox"/> Homeless                |
| <input type="checkbox"/> COPD                           | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Mental illness           | <input type="checkbox"/> Long-term care resident |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> Substance use            | <input type="checkbox"/> Pregnant                |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Corticosteroid use       | <input type="checkbox"/> Age 65 or older         |

## Other Health Conditions

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## Advance Care Planning (check all that apply)

- HEALTH CARE ADVANCE DIRECTIVE OR LIVING WILL – Location, if known:
- POWER OF ATTORNEY– Location, if known:
- DO NOT RESUSCITATE (DNR) ORDER – Location, if known:
- PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST, MOLST OR POST)
- PSYCHIATRIC ADVANCE DIRECTIVE – Location, if known:

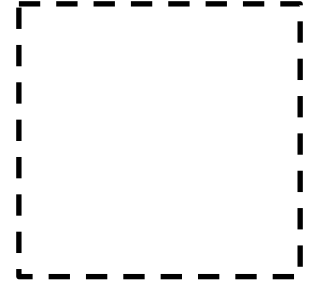
**IMPORTANT – Health Care Person-Centered Profile on Reverse Side**



# Health Care Person-Centered Profile

## *What Matters to Me*

Please call me



1. What people appreciate about me

2. Who and what is important to me

3. How to best support me

This Health Care Person-Centered Profile was completed by:  Me  Someone else  
Name and relationship):