



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):