CLEAR HOME SOLUTIONS™

HOME TRANSITIONS, ORGANIZATION & INVENTORY

My Health & Medical Information

Today's Date
(Revise the date each time you revise this document)

Contact Information
Name
Street Address
City, State, Zip Code
Home Phone
Cell Phone
Work Phone
Email
Social Security Number
Spouse's Name

Whom to Contact in Case of Emergency
Name
Home Phone
Cell Phone
Work Phone
Email

Primary Care Physician
Name
Phone
Affiliated Hospitals

Medical Insurance
Broker's Name
Insurance Company Name
Phone
Email
Your Group/Policy Number

Current Medications
(List the following information for each medication)
Drug Name
Dosage
Instructions (how often, with or without food, etc.)

For What Ailment
Doctor Prescribing It
When First Prescribed

Allergic Reactions
(For each allergy, please list the following information)
Allergy
How Severe
When It First Developed

Chronic Illnesses (such as diabetes, arthritis, etc.)
(For each illness, please list the following information)
Illness
How Severe
When It First Developed
Medical Specialist

Previous Illnesses (pneumonia, ulcers, etc.)
(List the most recent illness first, with the following information for each)
Illness
How Severe
When It First Developed
Medical Specialist Seen (if any)

Previous Surgeries/Accidents
(List the most recent surgery or accident, with the following information for each)
Date
Surgery For/Accident
Outcome
Doctor(s) You Saw
Dr.'s Phone

Family History of Illness
(Please list the following for each family member that suffered an illness)
Family Member (mother, sibling, grandparent)
Illness
Age at Which It Occurred

Your Social History
(Provide yes/no answer and the additional information for each)
Alcohol – Yes/No

Frequency of use
Smoking – Yes/No
Frequency of use
Drug/Substance use – Yes/No
Frequency of use

Lifestyle
How Frequently You Exercise
What Kind of Exercise
Healthy Diet – Yes/No
Vegetarian - Yes/No
Gluten-Free - Yes/No
Foods You Avoid for Medical Reasons

Pharmacy
Drugstore/Pharmacy name
Pharmacist's Name
Phone
Fax
Street Address
City, State, Zip Code

Important Documents
Do you have:
Living Will – Yes/No
Health Care Proxy – Yes/No
Advanced Medical Directive – Yes/No
Power of Attorney - Yes/No
Where are These Documents Kept
Who has Copies of Them
If "yes" for the Power of Attorney, to whom have you assigned it?
Name
Home Phone
Cell Phone
Work Phone
Email

Your Attorney
Name
Law Fim's Name
Work phone

Cell phone
Fax
Email
Street Address
City, State, Zip Code

Any Additional Information You'd Like to Add