

IMMUNIZATIONS

Tetanus:..... yes no Most Recent Date: _____

Tuberculosis:..... yes no Most Recent Date: _____

Flu Shot:..... yes no Most Recent Date: _____

Hepatitis B:..... Dose #1: _____ Date: _____ Dose #2: _____ Date: _____ Dose #3: _____ Date: _____

Pneumococcal Vaccine: yes no Most Recent Date: _____

Meningococcal Vaccine: yes no Most Recent Date: _____

Travel Related Vaccinations: *(Please indicate type and date)* _____

Other: *(Please indicate type and date)* _____

Childhood Immunization for	BOOSTER 1		BOOSTER 2		BOOSTER 3	
	Age	Date	Age	Date	Age	Date
Diphtheria						
Pertussis/Whooping Cough						
Polio						
Smallpox						
Typhoid						
Rubella						
Mumps						
Measles						
Other						

AT THE DOCTOR'S OFFICE

QUESTIONS FOR EVERY DOCTORS VISIT THAT WILL HELP ME UNDERSTAND MY HEALTH.

1. WHAT IS MY MAIN PROBLEM?
2. WHAT DO I NEED TO DO?
3. WHY IS IT IMPORTANT FOR ME TO DO THIS?

HNE Personal Health Record

for Adults



PERSONAL INFORMATION

Name					
Address					
City				State	Zip
Home Phone ()		Work Phone ()		Cell Phone ()	
Date of Birth	Male/Female	Height	Weight	Eye Color	Blood/RH Type
Languages Spoken					
Medications You Are Allergic To:					

IN CASE OF AN EMERGENCY NOTIFY:

Name			Relationship		
Address					
City				State	Zip
Home Phone ()		Work Phone ()		Cell Phone ()	
Healthcare Proxy <input type="checkbox"/> yes <input type="checkbox"/> no who:				Where are copies?	

INSURANCE INFORMATION

Primary Health Insurance Carrier	Policy Number	Phone ()
Secondary Health Insurance Carrier	Policy Number	Phone ()
HNE Case Manager		Phone ()

HEALTHCARE PROVIDERS

Primary Care Physician	Phone ()
Specialist/Type	Phone ()
Specialist/Type	Phone ()
Dentist	Phone ()
Pharmacy	Phone ()

