

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 Children and Adolescents



PERSONAL INFORMATION

Name							
Address							
City						State	Zip
Home Phone ()			Work Phone ()			Cell Phone ()	
Date of Birth	Male/Female	Eye Color	Blood/RH Type	Languages Spoken			
Medication Allergies:							
Date of Physical Exam:	Weight	Date of Physical Exam:	Weight	Date of Physical Exam:	Weight	Date of Physical Exam:	Weight
	Height		Height		Height		Height

PARENTS/GUARDIANS

Name							
Address							
City						State	Zip
Home Phone ()			Work Phone ()			Cell Phone ()	

IN CASE OF AN EMERGENCY NOTIFY: PARENT/GUARDIAN LISTED ABOVE

Other contact if not Parent/Guardian or Parent /Guardian not available							
Name						Relationship	
Address							
City						State	Zip
Home Phone ()			Work Phone ()			Cell Phone ()	

INSURANCE INFORMATION

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

