

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
		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 ()		

