

# My Personal Health Information / History

## Emergency Contacts For You

Name	Your relationship (family, friend, etc.)	Contact information

### Important Documents For Your Health

**Note:** *If you have these documents, then you may choose to keep copies (not originals) of these documents in this binder.*

**Do you have a Durable Power of Attorney (POA)?**  Yes  No

**If yes:** Name of Durable POA: \_\_\_\_\_

Phone number of Durable POA: \_\_\_\_\_

**Do you have a Living Will?**  Yes  No

**If yes:** Where is a copy kept?

**“Physicians should not treat the disease, but the patient who is suffering from it.”**  
- Maimonides



## Do you have any ALLERGIES?

Date	Allergy: Drug, Food, Other	Type Of Reaction/Treatment Received

### Have you had any reactions to drugs/anesthesia?

Types of reactions to drugs or anesthesia could include: itching, hives, shortness of breath, nausea and other reactions.

Have you received anesthesia before?  Yes  No

Did you have a reaction?  Yes  No

Date	Drug / Anesthesia	Type Of Reaction	Treatment Received





## What is your SURGICAL HISTORY?

Date	Diagnosis	Comments

**Family Medical History:** Describe any close family members with medical diagnoses that could be related to your health: cancer, heart disease, diabetes, etc.

Family Members	Diagnosis	Comments

Is there any other information that you would like to share with your healthcare providers that will help them to provide the best care to you?

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### Doctor Contact Information:

Include your primary care doctor and specialists:

Doctor Names	Phone Numbers	Address	Reason For Visiting This Doctor





## Notes