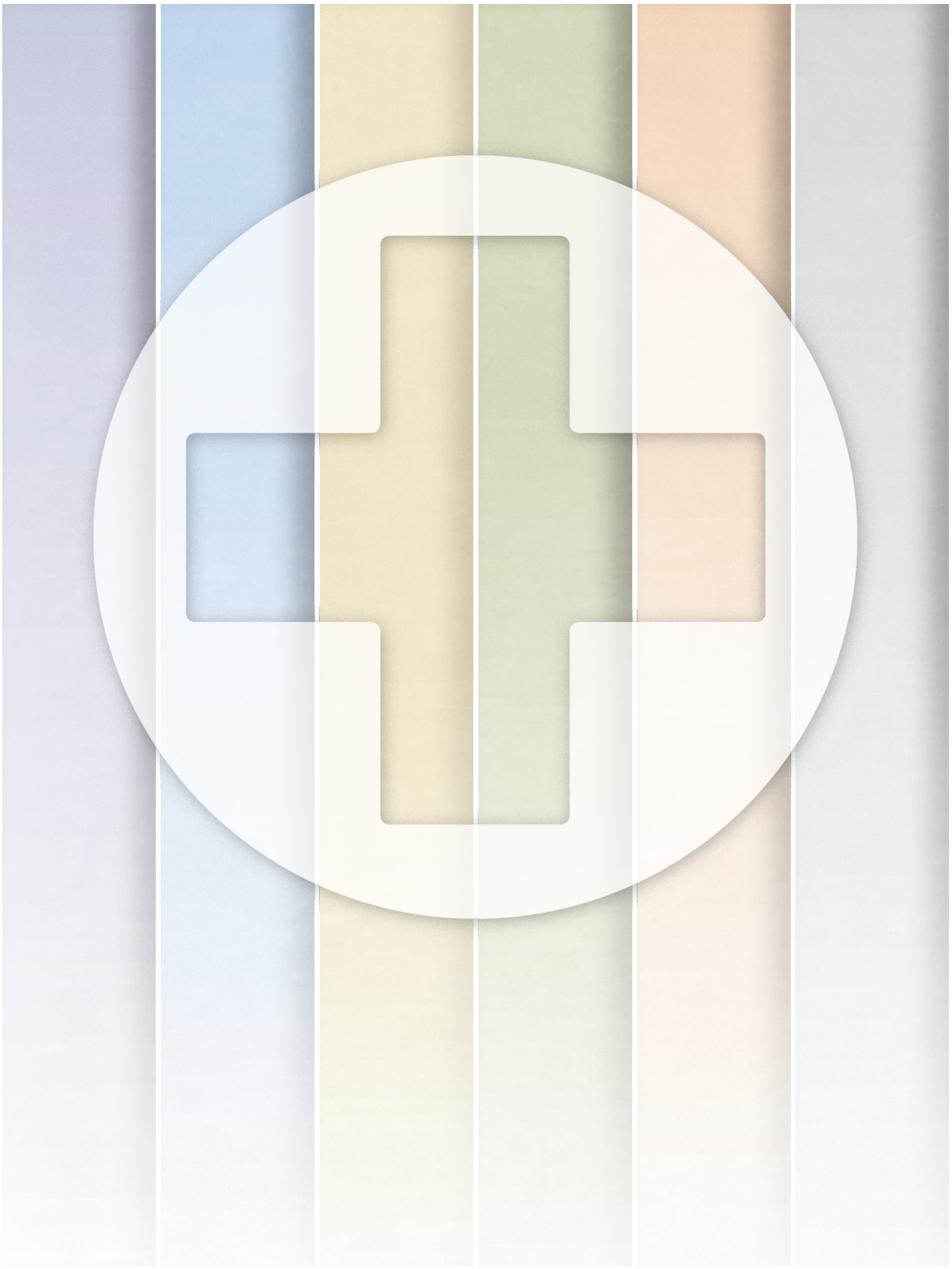
PROVIDENCE LIFE SERVICES

HEALTH INFO KIT



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Use this tool as a way to keep all your important health information in one organized place. Customize it to meet your own needs — use only the sections that you find helpful! Then store everything in a distinctive file folder or binder that you can grab easily when you go to the doctor. And let your family know where the binder is stored, so they can find it if you ever need their help.

CONTENTS

EMERGENCY CONTACT INFORMATION

PATIENT INFORMATION		
Name	Date of Birth	SS#
Home address Mailing address		Home Phone Cell Phone

PHYSICIAN(S)	PHYSICIAN PHONE	PHARMACY	PHARMACY PHONE

EMERGENCY CONTACTS				
NAME	RELATIONSHIP	HOME PHONE	MOBILE PHONE	WORK PHONE

MEDICAL CONDITIONS / DISEASES	
1.	4.
2.	5.
3.	6.

ALLERGIES TO MEDICATIONS	
MEDICATION	REACTION

CURRENT MEDICATION INFORMATION

CURRENT MEDICATION REGIMEN				
Medication	Date Prescribed	Dosage	Frequency	Condition/Special Notes

PROVIDENCE LIFE SERVICES
18601 North Creek Drive, Tinley Park, Illinois 60477
1 (800) 509-2800

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OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS

List all over-the-counter drugs, vitamins, or supplements currently being taken.

OVER-THE-COUNTER DRUGS	
DRUG NAME	DATES

VITAMINS	
VITAMIN NAME	DATES

SUPPLEMENTS	
SUPPLEMENT NAME	DATES

DOCTOR & PHARMACY INFORMATION

PRIMARY CARE PHYSICIAN

NAME	PHONE NUMBER
HOSPITAL NAME	OFFICE ADDRESS

PHARMACIST

NAME	PHONE NUMBER
PHARMACY NAME	OFFICE ADDRESS

DENTIST

NAME	PHONE NUMBER
BUSINESS NAME	OFFICE ADDRESS

OPTOMETRIST

NAME	PHONE NUMBER
PRACTICE NAME	OFFICE ADDRESS

AUDIOLOGIST

NAME	PHONE NUMBER
PRACTICE NAME	OFFICE ADDRESS

OTHER PHYSICIANS

NAME	PHONE NUMBER	SPECIALTY
NAME	PHONE NUMBER	SPECIALTY
NAME	PHONE NUMBER	SPECIALTY

If you have business cards for your attorney and executor, photocopy them and file the photocopies in this section. Or complete the form below.

ATTORNEY

NAME	PHONE NUMBER
PRACTICE NAME	OFFICE ADDRESS

EXECUTOR

NAME	PHONE NUMBER
ADDRESS	

ALSO INCLUDE IN THIS SECTION PHOTOCOPIES OF YOUR ADVANCE DIRECTIVES, INCLUDING —

DURABLE POWER OF ATTORNEY FOR HEALTHCARE
(available from your healthcare provider, the Senior Council on Aging, or various sources online)

DURABLE POWER OF ATTORNEY FOR PROPERTY
(available from your bank, attorney, or various sources online)

LIVING WILL

DO NOT RESUSCITATE (DNR) orders

MAKING THE MOST OF YOUR DOCTOR VISITS

Save this blank page as an original you can photocopy or re-print before each doctor visit. The form is designed to help you prepare for your meetings with the doctor, and to give you something to refer to after you get back home. Keep a copy of your completed forms in the Health History section of this Health Info Kit.

Doctor | _____ Date of appointment | _____

Reason for visit | _____

QUESTIONS TO ASK	DOCTOR'S ANSWERS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

Follow-up instructions | _____

Next appointment date | _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

DATES REVISED | ORIGINAL DATE |

NAME (Last, First, M.I.): ○ M ○ F **DOB** |

MARITAL STATUS | ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Previous or referring doctor | Date of last physical exam |

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS | ○ Measles ○ Mumps ○ Rubella ○ Chickenpox ○ Rheumatic Fever ○ Polio

IMMUNIZATIONS AND DATES | ○ Hepatitis ○ Influenza ○ Tetanus ○ Pneumonia ○ Chicken pox ○ MMR (Measles, Mumps, Rubella)

List any medical problems that other doctors have diagnosed |

SURGERIES		
YEAR	REASON	HOSPITAL

OTHER HOSPITALIZATIONS		
YEAR	REASON	HOSPITAL

TESTS (INDICATE DATE OF TEST, AND RESULTS IF KNOWN)		
	COLONOSCOPY	
	RECTAL/PELVIC EXAM	
	MAMMOGRAM	
	BONE DENSITY TEST	
	CHOLESTEROL SCREENING	

Have you ever had a blood transfusion? ○ YES ○ NO

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS (such as vitamins and inhalers)		
Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

EXERCISE	○ Sedentary *(No exercise)*					
	○ Mild exercise *(i.e., climb stairs, walk 3 blocks, golf)*					
	○ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	○ Regular vigorous exercise *(i.e., work or recreation 4x/week for 30 minutes)*					
DIET	Are you dieting?				○ Yes	○ No
	If yes, are you on a physician-prescribed medical diet?				○ Yes	○ No
	# of meals you eat in an average day?					
	Rank salt intake	○ Hi	○ Med	○ Low		
	Rank fat intake	○ Hi	○ Med	○ Low		
CAFFEINE	○ None	○ Coffee	○ Tea	○ Cola		
	# of cups/cans per day?					
ALCOHOL	Do you drink alcohol?				○ Yes	○ No
	How many drinks per week?					
	Have you ever experienced blackouts?				○ Yes	○ No
	Are you prone to "binge" drinking?				○ Yes	○ No
	Do you drive after drinking?				○ Yes	○ No
TOBACCO	Do you use tobacco?				○ Yes	○ No
	○ Cigarettes – pks./day	○ Chew - #/day	○ Pipe - #/day	○ Cigars - #/day		
	○ # of years	○ Or year quit				
DRUGS	Do you currently use recreational or street drugs?				○ Yes	○ No
	Have you ever given yourself street drugs with a needle?				○ Yes	○ No

SEX	Are you sexually active?	○ Yes	○ No
	Any discomfort with intercourse?	○ Yes	○ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	○ Yes	○ No
PERSONAL SAFETY	Do you live alone?	○ Yes	○ No
	Do you have frequent falls?	○ Yes	○ No
	Do you have vision or hearing loss?	○ Yes	○ No
	Do you have an Advance Directive or Living Will?	○ Yes	○ No
	Would you like information on the preparation of these?	○ Yes	○ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	○ Yes	○ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	○ M ○ F	
MOTHER				○ M ○ F	
SIBLING	○ M ○ F			○ M ○ F	
	○ M ○ F			○ M ○ F	
	○ M ○ F		Grandmother Maternal		
	○ M ○ F		Grandfather Maternal		
	○ M ○ F		Grandmother Paternal		
	○ M ○ F		Grandfather Paternal		

MENTAL HEALTH

Is stress a major problem for you?	○ Yes	○ No
Do you feel depressed?	○ Yes	○ No
Do you panic when stressed?	○ Yes	○ No
Do you have problems with eating or your appetite?	○ Yes	○ No
Do you cry frequently?	○ Yes	○ No
Have you ever attempted suicide?	○ Yes	○ No
Have you ever seriously thought about hurting yourself?	○ Yes	○ No
Do you have trouble sleeping?	○ Yes	○ No
Have you ever been to a counselor?	○ Yes	○ No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Date of onset of menopause:		
Number of pregnancies _____ Number of live births _____		
Have you had a D&C, hysterectomy, or Cesarean?	○ Yes	○ No
Any urinary tract, bladder, or kidney infections within the last year?	○ Yes	○ No
Do you usually get up to urinate during the night?	○ Yes	○ No
Any blood in your urine?	○ Yes	○ No
Any problems with control of urination?	○ Yes	○ No
Any hot flashes or sweating at night?	○ Yes	○ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	○ Yes	○ No
Date of last pap and rectal exam:		

MEN ONLY		
Do you usually get up to urinate during the night?	○ Yes	○ No
If yes, # of times _____		
Do you feel pain or burning with urination?	○ Yes	○ No
Any blood in your urine?	○ Yes	○ No
Do you feel burning discharge from penis?	○ Yes	○ No
Has the force of your urination decreased?	○ Yes	○ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	○ Yes	○ No
Do you have any problems emptying your bladder completely?	○ Yes	○ No
Any difficulty with erection or ejaculation?	○ Yes	○ No
Any testicle pain or swelling?	○ Yes	○ No
Date of last prostate and rectal exam:	○ Yes	○ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

○ Skin	○ Chest/Heart	○ Recent changes in:
○ Head/Neck	○ Back	○ Weight
○ Ears	○ Intestinal	○ Energy level
○ Nose	○ Bladder	○ Ability to sleep
○ Throat	○ Bowel	○ Other pain/discomfort:
○ Lungs	○ Circulation	