Original Date:
Dates Revised:

YOUR MEDICAL PASSPORT

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Emergency Contact:	Phone:	Relationship:
Secondary Emergency Contact:	Phone:	Relationship:

Primary Care Physician:		Address & Phone:	
Advanced Directive? ☐ Yes ☐ No		**Is copy attached?** ☐ Yes ☐ No	
Hospital Preference:			
Primary Insurance:	Phone:	**Policy Number:**	
Secondary Insurance:	Phone:	**Policy Number:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Risk Factors

Medical Diagnosis/Conditions

Date of Onset	Diagnosis/Condition	Name & Phone # of Physician seen for this condition

Surgeries/Hospitalizations		
Year	Reason	Hospital

Healthcare Providers			
	Provider	**Address**	**Phone**
Medical Equipment			
Pharmacy			
Home Health			
Other:			
Other:			
Other Physicians not listed with condition above			

Prescribed drugs, Illicit drugs, and Over-the-counter drugs, such as vitamins, herbal remedies, and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

FUNCTIONAL STATUS

Ambulation or Wheelchair Mobility	☐ Independent	☐ Needs Assistance	☐ Dependent	Assistive Device:
Stairs	☐ Independent	☐ Needs Assistance	☐ Dependent	Assistive Device:
Bathing	☐ Independent	☐ Needs Assistance	☐ Dependent	Assistive Device:
Dressing	☐ Independent	☐ Needs Assistance	☐ Dependent	Assistive Device:
Grooming	☐ Independent	☐ Needs Assistance	☐ Dependent	Assistive Device:

Communication	☐ Independent	☐ Needs Assistance	☐ Dependent	Assistive Device:
Vision	☐ Independent	☐ Impaired	☐ Blind	Assistive Device:
Hearing	☐ Independent	☐ Impaired	☐ Deaf	Assistive Device:
Eating	☐ Independent	☐ Needs Assistance	☐ Dependent	Assistive Device:
Swallowing	☐ No precautions	☐ Precautions:		
Diet	☐ No restrictions	☐ Restrictions:		
Prosthetics or Orthotics:		**Other Assistive Devices or Equipment:**		