HEALTH HISTORY

Name:	**Today's Date:**
Condo#: **Home Phone#:**	**Date of Birth:**
•Doctor: **•Pharmacy:**	

MEDICAL HISTORY: *List*	**Immunizations:**	**Advanced Directives/ Insurance**
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Pneumonia Vaccine Date Received: ☐ Shingles Vaccine Date Received: ☐ Flu Vaccine Date Received: ☐ Covid 19 Date Received:	Do we have a copy of your Advanced Directives? Please circle one YES NO Do we have a copy of your Do Not Resuscitate Order/POLST? Please circle one YES NO Do we have a copy of your current insurance cards? Please circle one YES NO

If more space is needed, please use the other side of this page.

MEDICATIONS		
List your prescribed drugs and over-the-counter drugs, such as vitamins/supplements.		
Name the Drug	Strength	Frequency Taken

Allergies	☐ **No Known Allergies**
Name the Allergen/Drug	Reaction You Had

If more space is needed for medications or allergies, please use the other side of this page.

EMERGENCY CONTACT #1		
Name:	Home Phone:	Email:
Relationship:	Cell Phone:	POA: YES NO
EMERGENCY CONTACT #2		
Name:	Home Phone:	Email:
Relationship:	Cell Phone:	POA: YES NO

Medical History Continued	Medications Continued	Allergies Continued