PATIENT HEALTH RECORD
KNOW YOUR HEALTH NUMBERS

Name:_____

Date:_____

Doctor & Clinic Information

Name:_____

Phone:_____

Pharmacy

Name:_____

Phone:_____

Personal Emergency Contact:

Name:_____

Phone:_____

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1. My blood type is_____
2. Blood Pressure_____ / _____
   a. BP Goal _____
3. Height _____
4. Weight _____
5. BMI (calculation) _____
6. Glucose/Sugar _____
7. Cholesterol _____ _____ _____
   HDL LDL Total
8. Medical History of Parents & Siblings
9. Names of All Medications; Over-the-Counter, Prescriptions & Supplements
10. Names of Medical Professionals
11. Date of last vaccination:
    a. Flu _____
    b. Pneumonia _____
    c. Tetanus _____
    d. Shingles _____
12. Date of last screening:
    a. Colon _____
    b. Mammogram _____
    c. Bones _____
    d. Eyes _____
    e. Vision _____
    f. Hearing _____
13. Date of last Dental Cleaning: _____
14. Allergies: