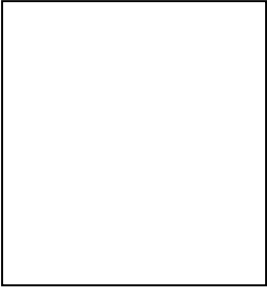


Additional Comments:

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HEALTH PASSPORT	
EMERGENCY AND OTHER INFORMATION	
Date of Photo	

Name:	
Address: _____	
Phone No:	
Social Security #	
Date of Birth:	
IN AN EMERGENCY PLEASE NOTIFY:	
Name:	
Address:	_____
Phone:	Home
	Work
MCO:	
I.D. No.	
Type of Disability:	
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Developmental Disability
Other:	
Allergic To:	_____
Communication:	
<input type="checkbox"/> Cannot Hear	<input type="checkbox"/> Cannot Speak
<input type="checkbox"/> Can Hear	<input type="checkbox"/> Can Speak
How I communicate when I'm not well:	
Symptoms that show you I'm not well:	
Normally, I cooperate well but if there are problems, you should:	
What an emergency looks like for me and what to do:	

PERSONAL INFORMATION

Sex: Female Male
 Height: _____ Ft _____ In. Weight: _____
 Hair: _____ Eyes: _____ Race: _____

PRIMARY CONTACT SOURCE:

Doctor: _____ Phone: _____
 Dentist: _____ Phone: _____
 Optician: _____ Phone: _____
 Other: _____ Phone: _____
 _____ Phone: _____
 Diet/Patterns/Preferences: _____

Special Needs/Techniques for dining/nutrition:

Case Worker: _____ Phone: _____

PHYSICAL FEATURES

- Hearing aid (L-R) Dentures
 - Bridgework Prothesis
 - Glasses Contacts
 - Scar: _____ Tattoo: _____
- Mobility:** Walks unassisted
 Cane Walker Wheelchair

Transferring Needs:

Special care of personal equipment:

HEALTH HISTORY

YOURSELF FAMILY

Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Encephalitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
T.B.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer:				
Ovarian	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other:				
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Huntington's	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis (Type) :				
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure:				
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Comments:

MEDICATION INFORMATION

PRESCRIPTION	STRENGTH	DOSAGE	ROUTE ADMINISTERED	WHEN ADMINISTERED	HOW LONG PRESCRIBED

Special Instructions for Administering Medication

Person Completing Health Passport:

Signature

Title

Date Completed