|  |  |
| --- | --- |
| Health History Form | |
| Name |  |
| Date of Birth |  |
| Social Security or Insurance ID Number |  |
| Medical Insurance Company Name and Phone Number |  |
| Name of Emergency Contact |  |
| Phone Number of Emergency Contact |  |
| Primary Doctor’s Contact Information |  |
| Name and Phone Number of Preferred Hospital |  |
| Location of Advance Directives |  |
| Allergies or Reactions to Medications |  |
| History of Medical Problems  (indicate if you have had or are treated for any) | * Heart Disease □ High Blood Pressure * High Cholesterol □ Diabetes * Asthma/Lung Disease □ Thyroid Problem * Kidney Disease □ Cancer (Specify): * Depression * Other (Specify): |

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