

Diabetes Wellness Clinic of America

Health Information Form *for Adults*



A. IDENTIFICATION

Name (Last)		(First)	(Middle)
Maiden Name			
Primary Address			
City	State	Zip Code	Country
Alternate Address			
City	State	Zip Code	Country
Home Phone		Work Phone	
Cell Phone		E-mail Address	
Date of Birth		☐ Male	☐ Female
Height	Weight	Eye Color	Hair Color
Ethnicity/Race		Birthmarks/Scars	
Blood / RH Type		Special Conditions	Marital Status
Occupation			
Company Name			
Address			
City	State	Zip Code	Country
Phone Number		Languages Spoken—Primary and Secondary	
Primary Health Insurance Carrier		Policy Number	
Secondary Health Insurance Carrier		Policy Number	

B. EMERGENCY CONTACTS

<i>In Case of Emergency, Notify: Primary Contact</i>			
Name (Last)		(First)	(Middle)
Relationship			
Address			
City	State	Zip Code	Country
Home Phone		Work Phone	
Cell Phone		E-mail Address	
<i>In Case of Emergency, Notify: Secondary Contact</i>			
Name (Last)		(First)	(Middle)
Relationship			
Address			
City	State	Zip Code	Country
Home Phone		Work Phone	
Cell Phone		E-mail Address	
<i>In Case of Emergency, Notify: Medical Contact</i>			
Physician (Indicate Specialty)			
Phone			
Dentist		Phone	
Pharmacy		Phone	

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C. HEALTHCARE PROVIDERS

Healthcare Provider Speciality		Primary Care Physician ☐ Yes ☐ No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		

Healthcare Provider Speciality		Primary Care Physician ☐ Yes ☐ No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		

Healthcare Provider Speciality		Primary Care Physician ☐ Yes ☐ No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		

Healthcare Provider Speciality		Primary Care Physician ☐ Yes ☐ No		Phone	Emergency Phone No. (after hours)
Name					
Group or Association					
Address					
City	State	Zip Code	Country		

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D. INSURANCE PROVIDERS

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/URL			
Address				Primary Insured Person—Name		Social Security No.	
City		State	Zip Code	Employer Name			
Contact—Name		Phone					
Identification—Group Number		Member (ID) Number					
Contact Information—Phone			Emergency Phone No. (after hours)				
				Address			
City		State	Zip Code	Country			
				Phone Number			

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/URL			
Address				Primary Insured Person—Name		Social Security No.	
City		State	Zip Code	Employer Name			
Contact—Name		Phone					
Identification—Group Number		Member (ID) Number					
Contact Information—Phone			Emergency Phone No. (after hours)				
				Address			
City		State	Zip Code	Country			
				Phone Number			

Insurance Provider Type				E-mail Address		Fax	
Company Name				Web Address/URL			
Address				Primary Insured Person—Name		Social Security No.	
City		State	Zip Code	Employer Name			
Contact—Name		Phone					
Identification—Group Number		Member (ID) Number					
Contact Information—Phone			Emergency Phone No. (after hours)				
				Address			
City		State	Zip Code	Country			
				Phone Number			

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E. LEGAL DOCUMENTS/MEDICAL DIRECTIVES

☐ Living Will				☐ Durable Power of Attorney for Healthcare			
☐ Power of Attorney							
Document Location (Physical Location)							
Location Name (for example, Bank of America)							
Address							
City		State	Zip Code	Country			
Legal Representative (Name of person who you have assigned legal authority)							
Address							
City		State	Zip Code	Country			
Contact Information							
Home Phone			Cell Phone				
Pager			E-mail Address				
Work E-mail Address			Work Phone				

Fax			
Contact (Name of person who has access to the document)			
Address			
City	State	Zip Code	Country
Contact Information			
Home Phone		Cell Phone	
Pager		E-mail Address	
Work Phone		Work E-mail Address	
Fax			
Date Filed			
Organ Donation		State Where Registered	
Organ Donor ☐ Yes			
☐ No			

☐ Living Will				☐ Durable Power of Attorney for Healthcare			
☐ Power of Attorney							
Document Location (Physical Location)							
Location Name (for example, Bank of America)							
Address							
City		State	Zip Code	Country			
Legal Representative (Name of person who you have assigned legal authority)							
Address							
City		State	Zip Code	Country			
Contact Information							
Home Phone			Cell Phone				
Pager			E-mail Address				
Work E-mail Address			Work Phone				

Fax			
Contact (Name of person who has access to the document)			
Address			
City	State	Zip Code	Country
Contact Information			
Home Phone		Cell Phone	
Pager		E-mail Address	
Work Phone		Work E-mail Address	
Fax			
Date Filed			
Organ Donation		State Where Registered	
Organ Donor ☐ Yes			
☐ No			

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F. MEDICAL HISTORY check appropriate

	Date of Onset		Date of Onset
☐ Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive		☐ High Blood Pressure	
☐ Arthritis		☐ Hypoglycemia	
☐ Asthma		☐ Jaundice	
☐ Bronchitis		☐ Kidney Disease	
☐ Cancer		☐ Low Blood Pressure	
☐ Chlamydia		☐ Mental Retardation	
☐ Diabetes		☐ Pain or Pressure in Chest	
☐ Dizziness		☐ Palpitations	
☐ Emphysema		☐ Periods of Unconsciousness	
☐ Epilepsy		☐ Rheumatic Fever	
☐ Eye Problem		☐ Rheumatism	
☐ Fainting		☐ Seizures	
☐ Frequent or Severe Headache		☐ Shortness of Breath	
☐ Glaucoma		☐ Stomach, Liver, or Intestinal Problems	
☐ Gonorrhea		☐ Syphilis	
☐ Hearing Impairment		☐ Tuberculosis	
☐ Heart Condition		☐ Tumor	
☐ Hemodialysis		☐ Thyroid Problems	
☐ Herpes		☐ Urinary Tract Infection	
☐ High Blood Cholesterol		☐ Other	

G. INFECTIOUS DISEASES

Disease	Age	Date	Remarks
Chicken Pox			
Hepatitis			
Measles			
Mumps			
Pertussis / Whooping Cough			
Pneumonia			
Polio			
Rubella			
Scarlet Fever			
Other			

H. IMMUNIZATIONS

			BOOSTER 1		BOOSTER 2		BOOSTER 3	
Immunization for	Age	Date	Age	Date	Age	Date	Age	Date
Diphtheria								
Hepatitis B								
Measles								
Mumps								
Pertussis/Whooping Cough								
Polio								
Rubella								
Smallpox								
Tetanus								
Tuberculosis								
Typhoid								
Other								

I. ALLERGIES/DRUG SENSITIVITIES

Allergy/Sensitivity Type (include medications, foods, environmental, or other)	Reaction	Date Last Occurred	Treatment

J. FAMILY MEMBER HISTORY

	Mother	Father	Sibling(s)	Grandparent(s)	Children
Enter ages of relatives					
If deceased, indicate age and cause of death					
Check all items that apply for their present state of health or any illnesses they have had.					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
Hemodialysis					
Hepatitis					
High Blood Cholesterol					
High Blood Pressure					
Kidney Disease					
Mental Retardation					
Rheumatic Fever					
Seizures					
Smoking					
Stomach, Liver, or Intestinal Problems					
Stroke					
Thyroid Disorders					
Tuberculosis					
Tumor					
Other					



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K. LIFESTYLE

Form section K: Lifestyle. Includes checkboxes for Alcohol, Smoking, and Exercise, with corresponding fields for frequency and duration.

L. HEALTH LOG

Noninfectious major illnesses. Include pregnancies and childbirth.

Table with 6 columns: Date Diagnosed, Doctor, Nature of Health Problem, Age at Onset, Condition Status, Remarks. Contains 15 empty rows for data entry.

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M E D I C A T I O N S (Prescription/Non-Prescription) Update Regularly

Note: Include all prescription medications, (such as nitroglycerin) over-the-counter medications (taken on a regular basis), vitamin supplements, and herbal remedies.

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N. DOCTOR VISITS

[illegible]

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O . HOSPITALIZATIONS

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

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P. SURGERIES

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

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Q. LAB OR IMAGING (Examples: X-ray, MRI, Mammogram)

Form for Lab or Imaging tests, including Test Type, Date, Requesting Doctor, Administered by, Reason, and Result.

Form for Lab or Imaging tests, including Test Type, Date, Requesting Doctor, Administered by, Reason, and Result.

R. MEDICAL DEVICES (Examples: pacemaker, insulin pumps, breathing devices)

Form for Medical Devices, including Device Type, Doctor, Hospital, Date, Reason, and Result.

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S. PHYSICAL/OCCUPATIONAL THERAPY

[illegible]

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T . VISION

Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	

Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	

Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	

U . DENTAL

Date of Visit	Dentist	Problems	Resolution