HEALTH HISTORY

HELPFUL TIP **Complete this form and file in the kit. This will help establish a medical history and help you prepare for future health care visits.**

Name	Age/Birth Date
Address	City/State/Zip
Phone	Primary Support Person's phone number
Primary Care Physician	Clinic
MA/Insurance numbers	

Doctors I have seen in the last two years:

Name	Reason

I am being or have been treated for:

Condition	Check box if current condition	Date diagnosed
High/Low Blood Pressure		
Diabetes		
Seizures		
Arthritis		
Depression/Anxiety		
Bladder infection		
Constipation/Diarrhea		
Stomach problems		
Heart problems		
Breathing problems		
Cancer		
Other		

Copy this on White paper

My allergies:		
Foods	Medications	Other

My immunization records:			
Immunization	Date	Immunization	Date

My family health history:			
Family member	Diagnosis and date	Diagnosis and date	Diagnosis and date
Mother			
Father			
Brother			
Sister			

My medication history:					
Medicine	Directions/dosage	Purpose	Prescribed by	Date started	Date stopped

Memory tests I have completed:		
Test name	Completed by	Date completed

**If you have not taken a memory test, this kit includes the NTG-EDSD form that can be used as an initial baseline for the individual and then updated every 6 months. See the NTG-EDSD form for more information.*