

7. Medical and Health Information

Use this form to document your personal medical and health insurance data and to list your doctors and caregivers.

IMPORTANT: After you complete the forms in Part 2, print them and store them in a safe place in your house, as described on page 1.

Today's Date:

A. Your Personal Medical Profile

Name: _____

Date of Birth: _____ Blood Type: _____

B. Your Personal Physician

Name: _____

Cell Phone Number: _____ Office Phone Number: _____

Address: _____

Specialty: _____ Hospital Preference: _____

C. Your Specialty Caregivers

Name (1): _____

Cell Phone Number: _____ Office Phone Number: _____

Address: _____

Specialty: _____ Hospital Preference: _____

Notes:

Name (2): _____

Cell Phone Number: _____ Office Phone Number: _____

Address: _____

Specialty: _____ Hospital Preference: _____

Notes:

Name (3): _____

Cell Phone Number: _____ Office Phone Number: _____

Address: _____

Specialty: _____ Hospital Preference: _____

Notes:

7. Medical and Health Information (continued)

D. Medications You Take Regularly

List important medications you must take regularly (e.g., for diabetes, high blood pressure, high cholesterol, glaucoma, etc.).

Today's Date:

Medication (1): _____

Purpose (Diagnosis): _____ Dosage: _____

Prescribing Physician: _____

Medication (2): _____

Purpose (Diagnosis): _____ Dosage: _____

Prescribing Physician: _____

Medication (3): _____

Purpose (Diagnosis): _____ Dosage: _____

Prescribing Physician: _____

Medication (4): _____

Purpose (Diagnosis): _____ Dosage: _____

Prescribing Physician: _____

Medication (5): _____

Purpose (Diagnosis): _____ Dosage: _____

Prescribing Physician: _____

Medication (6): _____

Purpose (Diagnosis): _____ Dosage: _____

Prescribing Physician: _____

Notes:

E. Medical Devices and Implants

List here such items as heart pacemakers, gastric bands, artificial hips or other limbs, colostomy, breast implants, etc.

Device (1): _____

Purpose (Diagnosis): _____ Date initiated: _____

Device (2): _____

Purpose (Diagnosis): _____ Date initiated: _____

Device (3): _____

Purpose (Diagnosis): _____ Date initiated: _____

Notes:

7. Medical and Health Information (continued)

F. Private Health Insurance Information

Today's Date:

Policyholder (1):

Address: _____

Agent Name _____

Phone: _____

Issuer: _____

Policy No.: _____

Phone for Approvals: _____

Policyholder (2):

Address: _____

Agent Name _____

Phone: _____

Issuer: _____

Policy No.: _____

Phone for Approvals: _____

G. IMSS (Mexican National Health Insurance) Information

Registered Name: _____

Registered Address: _____

NSS No.: _____

R.P. No.: _____

Calidad No.: _____

Exp. Date: _____

H. Life Insurance Information

Policyholder (1):

Address: _____

Agent Name _____

Phone: _____

Issuer: _____

Policy No.: _____

Policyholder (2):

Address: _____

Agent Name _____

Phone: _____

Issuer: _____

Policy No.: _____