Health Care Plan (2021 Update)

Name: **DOB:**

Home address and telephone:
Contact person:
Family contact person: address and telephone

Heath Insurance :

Commercial insurance
Medi-Cal/Medi-Care
Dental Insurance

Others:

In case of emergency (ICE) contact:

Advance directives Emergency Contact: (Family or the community you are living with)

Date: (updated annually) or more frequently if intermittent illness occurs.

Primary Attending physician/telephone (and for what medical problem) :

Diagnoses:

1.

2.

3

4.

5.

Pharmacy: **(name and address)**

Telephone:

Weight/height

Name of medicine	**How much to take**	**Indication/reason**

1. Rx Drugs:

2. OTC meds (cover the counter):

Special Medical Clinics

Name of doctor	**Type of doctor**	**Medicine**

1. Family History:

   Alcohol Asthma Bleeding disorder Cancer Depression Diabetes Glaucoma Heart disease Lung Disease Kidney Disease Seizures Thyroid Disease

Father's Age at death: Mother's age at death:

Diet/Nutrition:

Equipment/supplies	**Company**	**Phone**

Activities of daily living: (walking, wheel chair, independent in preparing meal, out-shopping, activities outside the house without supervision?**)**

Glasses:
Dentures:
Incontinent/continent:
Fall risk?
Adaptive devices:
Driving:

Past surgeries:

Past emergency room visits (last 2 years):

Health History:

Eyes

Ears

Nose/Sinuses

Mouth/Throat

Neck

Heart

Stomach-Intestines/Endocrine

Kidney/Bladder

Muscle/Skeletal

Other Diseases