

## PERSONAL HEALTH RECORD

**YAO Clinic** recognizes the value of self-empowerment when making health care choices. We invite you to take control of your health by assembling your health history. This comprehensive Personal Health Record can be useful for any health practitioner in identifying key moments during which significant events contributed to your current health condition. This form is for your personal use, and is separate from our Clinic intake form.

### I. PERSONAL IDENTIFICATION

Last Name		First Name		Middle Name	
Birth Name		Birth Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex			
Date of Birth		Country of Birth			
Current Gender Identification <input type="checkbox"/> Male <input type="checkbox"/> Female		Surgical/Hormonal Gender Change? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Street Address					
City		State	Zip Code	Country	
Alternate (Mailing) Address					
City		State	Zip Code	Country	
Home Phone		Work Phone			
Mobile Phone		Email Address			
Current Height	Current Weight	Eye Color	Natural Hair Color		
Ethnicity		Significant Birth Marks/Scars			
Blood/RH Type		Significant Medical Diagnoses			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Committed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Occupation					
Employer			Phone Number		
Employer Address					
City		State	Zip Code	Country	
Primary Language		Secondary Language			

### II. EMERGENCY CONTACT INFORMATION

#### Primary Emergency Contact

Last Name		First Name		Middle Name	
Relationship					
Street Address					
City		State	Zip Code	Country	
Home Phone		Work Phone			
Mobile Phone		Email Address			

#### Secondary Emergency Contact

Last Name		First Name		Middle Name	
Relationship					
Street Address					
City		State	Zip Code	Country	
Home Phone		Work Phone			
Mobile Phone		Email Address			

#### Primary Medical Contacts

Physician's Name			Specialty		
Physician's Office Address					
City		State	Zip Code	Country	
Physician's Phone			Email Address		
Dentist's Name			Dentist's Phone		
Pharmacy			Pharmacy Phone		



**YAO Clinic**  
 303-777-7891 FAX: 303-777-7835  
 1305 South Washington Street  
 Denver, Colorado 80210  
 www.yaoclinic.com

Name \_\_\_\_\_

Date \_\_\_\_\_

# PERSONAL HEALTH RECORD

## III. HEALTH PRACTITIONERS

Type of Practice		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service(s) Provided			
Practitioner's Name			
Practitioner's Office Address			
City	State	Zip Code	Country
Practitioner's Phone		Email Address	
Clinic Name			

Type of Practice		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service(s) Provided			
Practitioner's Name			
Practitioner's Office Address			
City	State	Zip Code	Country
Practitioner's Phone		Email Address	
Group or Association			

Type of Practice		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service(s) Provided			
Practitioner's Name			
Practitioner's Office Address			
City	State	Zip Code	Country
Practitioner's Phone		Email Address	
Group or Association			

Type of Practice		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service(s) Provided			
Practitioner's Name			
Practitioner's Office Address			
City	State	Zip Code	Country
Practitioner's Phone		Email Address	
Group or Association			

Type of Practice		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service(s) Provided			
Practitioner's Name			
Practitioner's Office Address			
City	State	Zip Code	Country
Practitioner's Phone		Email Address	
Group or Association			

Type of Practice		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service(s) Provided			
Practitioner's Name			
Practitioner's Office Address			
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Group or Association			



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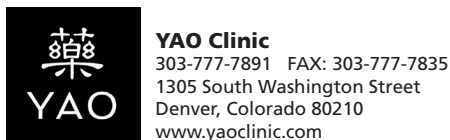
# PERSONAL HEALTH RECORD

## IV. INSURANCE PROVIDERS

Insurance Type				Email Address		Facsimile	
Company Name				Web Site Address			
Contact Name				Primary Insured Person's Name		SSN	
Mailing Address				Employer Name			
City		State	Zip Code	Employer Address		Country	
Phone		Emergency Phone					
Group Number ID			Member Number ID				
City		State	Zip Code	City		Country	
Phone			After Hours Phone				

Insurance Type				Email Address		Facsimile	
Company Name				Web Site Address			
Contact Name				Primary Insured Person's Name		SSN	
Mailing Address				Employer Name			
City		State	Zip Code	Employer Address		Country	
Phone		Emergency Phone					
Group Number ID			Member Number ID				
City		State	Zip Code	City		Country	
Phone			After Hours Phone				

Insurance Type				Email Address		Facsimile	
Company Name				Web Site Address			
Contact Name				Primary Insured Person's Name		SSN	
Mailing Address				Employer Name			
City		State	Zip Code	Employer Address		Country	
Phone		Emergency Phone					
Group Number ID			Member Number ID				
City		State	Zip Code	City		Country	
Phone			After Hours Phone				



Name \_\_\_\_\_

Date \_\_\_\_\_

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## V. MEDICAL DIRECTIVES & LEGAL DOCUMENTS

- Living Will       Durable Power of Attorney for Medical Decisions  
 Power of Attorney

Physical Location of Document(s) - ie, Safe Deposit Box Number

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Location Name

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Physical Address of Document Location

City	State	Zip Code	Country
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Contact Name	Phone
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Legal Representative (Person assigned legal authority)

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Physical Address

City	State	Zip	Country
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Business Phone	Home Phone
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Email Address	Mobile Phone
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Contact Person with Document Access

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Address

City	State	Zip Code	Country
------	-------	----------	---------

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Contact Information

Relationship	Home Phone
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Email Address	Mobile Phone
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Facsimile	Business Phone
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Date Filed

---

Organ Donor? <input type="checkbox"/> Yes <input type="checkbox"/> No	State Where Registered
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Specific Organs, if any, please list

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- Living Will       Durable Power of Attorney for Medical Decisions  
 Power of Attorney

Physical Location of Document(s) - ie, Safe Deposit Box Number

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Location Name

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Physical Address of Document Location

City	State	Zip Code	Country
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Contact Name	Phone
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Legal Representative (Person assigned legal authority)

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Physical Address

City	State	Zip	Country
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Business Phone	Home Phone
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Email Address	Mobile Phone
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Contact Person with Document Access

---

Address

City	State	Zip Code	Country
------	-------	----------	---------

---

Contact Information

Relationship	Home Phone
--------------	------------

---

Email Address	Mobile Phone
---------------	--------------

---

Facsimile	Business Phone
-----------	----------------

---

Date Filed

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Organ Donor? <input type="checkbox"/> Yes <input type="checkbox"/> No	State Where Registered
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Specific Organs, if any, please list

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# PERSONAL HEALTH RECORD

## VI. HEALTH HISTORY *(check all applicable items)*

Condition	Date of Onset	Date Resolved
<input type="checkbox"/> AIDS		
<input type="checkbox"/> HIV Positive		
<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Bronchitis		
<input type="checkbox"/> Cancer		
<input type="checkbox"/> Candida		
<input type="checkbox"/> Chest Pain or Pressure		
<input type="checkbox"/> Chlamydia		
<input type="checkbox"/> Cysts		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Digestive Problems		
<input type="checkbox"/> Dizziness		
<input type="checkbox"/> Emphysema		
<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Eye Problems		
<input type="checkbox"/> Fainting		
<input type="checkbox"/> Glaucoma		
<input type="checkbox"/> Gonorrhea		
<input type="checkbox"/> Headache (Chronic)		
<input type="checkbox"/> Hearing Impairment		
<input type="checkbox"/> Heart Condition		
<input type="checkbox"/> Heart Palpitations		
<input type="checkbox"/> Hemodialysis		
<input type="checkbox"/> Herpes		
<input type="checkbox"/> High Blood Cholesterol		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Hypoglycemia		
<input type="checkbox"/> Jaundice		
<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Liver Problems		
<input type="checkbox"/> Low Blood Pressure		
<input type="checkbox"/> Mental Retardation		
<input type="checkbox"/> Rheumatic Fever		
<input type="checkbox"/> Rheumatism		
<input type="checkbox"/> Seizures		
<input type="checkbox"/> Shortness of Breath		
<input type="checkbox"/> Skin Problems		
<input type="checkbox"/> Syphilis		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Tumor		
<input type="checkbox"/> Thyroid Disorders		
<input type="checkbox"/> Urinary Tract Infection		
<input type="checkbox"/> Other _____		

## VII. INFECTIOUS DISEASES

Disease	Age at Onset	Date
Chicken Pox		
Notes _____		
Hepatitis		
Notes _____		
Measles		
Notes _____		
Mumps		
Notes _____		
Pertussis/Whooping Cough		
Notes _____		
Pneumonia		
Notes _____		
Polio		
Notes _____		
Rubella		
Notes _____		
Scarlet Fever		
Notes _____		
Shingles		
Notes _____		
Other _____		
Notes _____		
Other _____		
Notes _____		
Other _____		
Notes _____		
Other _____		
Notes _____		



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## VIII. IMMUNIZATION RECORDS

IMMUNIZATION	Initial		First Booster		Second Booster		Third Booster	
	Age	Date	Age	Date	Age	Date	Age	Date
Diphtheria								
Haemophilus Influenza Type B								
Hepatitis A								
Hepatitis B								
Human Papillomavirus								
Influenza								
Measles								
Meningococcal								
Mumps								
Pertussis/Whooping Cough								
Pneumococcal								
Polio								
Rotavirus								
Rubella								
Smallpox								
Tetanus								
Tuberculosis								
Typhoid								
Varicella								
Other _____								
Other _____								

### UNUSUAL REACTIONS AND DATES OF ONSET

IMMUNIZATION	REACTION <i>(Describe in Detail)</i>	DATE OF REACTION

Name \_\_\_\_\_

Date \_\_\_\_\_

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## IX. FAMILY HISTORY

\* (M) Maternal (P) Paternal

	Mother	Father	Grandparents (M)*	Grandparents (P)*	Sibling(s)	Children
Date(s) of Birth						
Date(s) of Death						
Cause(s) of Death						
<b><i>Check all items that apply for each person's current state of health or illnesses they have had.</i></b>						
Alcoholism						
Arthritis						
Asthma						
Cancer						
Diabetes						
Digestive Disorders						
Emphysema						
Glaucoma						
Heart Condition						
Hemodialysis						
Hepatitis						
High Blood Cholesterol						
High Blood Pressure						
Kidney Disease						
Lung Disease						
Mental Retardation						
Rheumatic Fever						
Seizures						
Smoking						
Stroke						
Thyroid Disorders						
Tuberculosis						
Tumor						
Other						



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## X. LIFESTYLE

Alcohol  
 Now    Quit    Never   # Drinks per week \_\_\_\_\_ # of Years \_\_\_\_\_

Smoking  
 Now    Quit    Never   # Pack(s) per day \_\_\_\_\_ # of Years \_\_\_\_\_

Exercise  
 <30 mins/day    >30 mins/day    >60 mins/day  
 # Days per week    1-2    3-5    6-7

Types of exercise: \_\_\_\_\_

## XI. SLEEP HABITS

Uninterrupted hours of sleep per night, on average  
 1-2    3-4    5-6    7-8    9-10    11+

Frequency of awakenings, per night  
 1-2    3-4    5-6    7-8

Sleep Aids?  
 Sleep Mask    Ear Plugs  
 TV/Music/Sound/Reading    Supplements/Herbs  
 Prescription Medication    Meditation

Prescriptions, herbs or supplements you take for sleep: \_\_\_\_\_

## XII. VISION

Date of Visit \_\_\_\_\_ Physician Name \_\_\_\_\_

Vision Prescription \_\_\_\_\_

Diagnosed Eye Condition(s) \_\_\_\_\_

Practitioner's Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Practitioner's Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Clinic Name \_\_\_\_\_

Date of Visit \_\_\_\_\_ Physician Name \_\_\_\_\_

Vision Prescription \_\_\_\_\_

Diagnosed Eye Condition(s) \_\_\_\_\_

Practitioner's Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Practitioner's Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Clinic Name \_\_\_\_\_

## XIII. DENTAL

Date of Visit	Problem	Resolution	Dentist Name



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## XVIII. HOSPITALIZATIONS

Hospitalization Reason		Diagnosis
Date of Admission	Date of Discharge	
Attending Physician		
Hospital		
Reason for Admission		Complications

Hospitalization Reason		Diagnosis
Date of Admission	Date of Discharge	
Attending Physician		
Hospital		
Reason for Admission		Complications

Hospitalization Reason		Diagnosis
Date of Admission	Date of Discharge	
Attending Physician		
Hospital		
Reason for Admission		Complications



Name \_\_\_\_\_

Date \_\_\_\_\_

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## XIX. SURGERIES

Surgical Procedure		Results
Date of Procedure	Surgeon	
Hospital or Clinic		
Description of Procedure		
		Complications or Comments

Surgical Procedure		Results
Date of Procedure	Surgeon	
Hospital or Clinic		
Description of Procedure		
		Complications or Comments

Surgical Procedure		Results
Date of Procedure	Surgeon	
Hospital or Clinic		
Description of Procedure		
		Complications or Comments



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## XX. LAB TESTS & IMAGING

(e.g., X-Ray, MRI, CT, Mammogram, Stress Test)

Test Type	
Date of Test	Requesting Physician
Clinic, Imaging Center or Hospital Name	
Reason for Test	
Result of Test	

Test Type	
Date of Test	Requesting Physician
Clinic, Imaging Center or Hospital Name	
Reason for Test	
Result of Test	

Test Type	
Date of Test	Requesting Physician
Clinic, Imaging Center or Hospital Name	
Reason for Test	
Result of Test	

Test Type	
Date of Test	Requesting Physician
Clinic, Imaging Center or Hospital Name	
Reason for Test	
Result of Test	

## XXI. MEDICAL DEVICES

(e.g., Pacemaker, Oxygen, Breathing Devices, Insulin Pump)

Device Type	Physician
Date	Hospital
Reason for Device	
Comments	

Device Type	Physician
Date	Hospital
Reason for Device	
Comments	



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