1. Cut along outside, black line
2. Fold so "My Adult Health Record" is showing on top, outside

My Adult Health Record

My Name: ______________________

My Phone Number: ______________________

IN CASE OF EMERGENCY, CALL:

Name: ______________________

Phone Number: ______________________

MyBlood Type: ______________________

Extra forms available at www.gha.org/pha

Emergency Phone Numbers:

Primary Doctor: ______________________

Phone: ______________________

Durable Power of Attorney for Healthcare (contact for copy):

Name: ______________________

Phone Number: ______________________

My Living Will Directive for Final Healthcare (contact for copy):

Name: ______________________

Phone Number: ______________________

☐ I have no known allergies
☐ I am allergic to:

List your allergies:	The reaction I have is:

Immunizations/Medical History:

Vaccine	Date of last dose
☐ Flu Vaccine(s):	______________
☐ Flu - H1N1 Vaccine:	______________
☐ Pneumonia Vaccine:	______________
☐ Shingles:	______________
☐ Tetanus or Tdap	______________

Important Medical Problems:

☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Rare Blood Antibodies
☐ Other ______________

MEDICATIONS **(List all prescription medications):**

Include prescription medications taken as needed (example: nitroglycerine)

If you stop a medicine cross it off the list.

Name of Medication	Dose or Strength	Amount Taken or How Much	How Often or Time of Day Taken	Why Taking

OVER-THE-COUNTER MEDICATIONS:

Like: aspirin, antacids, cold or cough medicine, creams, inhalers, vitamins, and herbals like ginseng or gingko.

Name	Dose or Strength	Amount Taken or How Much	How Often or Time of Day Taken	Why Taking

Pharmacy Phone: ______________________

Other Pharmacy Ph: ______________________

Cut out on solid line