Hand in Hand Care
Care Management and Concierge Nursing
(941) 363-1809 info@handinhandcare.net

Personal Health History

Date: _____

Care Recipient's Name: _____ Date of Birth: _____
(Last) (First) (MM/DD/YY)

Address: _____
(Street) (City) (State) (Zip Code)

Phone No. (____) _____ E-Mail Address: _____

Emergency Contact: _____
(Name(s)) (Phone No.)

Whom do you live with? _____

Which setting best describes your home? _____
(i.e. residence, assisted living)

Do you have children? ○ Yes ○ No If Yes, What are your children's names? _____

_____

Please List any Allergies: _____

_____

Current Health Concerns/Symptoms: _____

_____

Past Surgeries or Hospitalizations: _____

_____

Current Health Care Providers: _____

_____

Do you have any safety concerns: _____

_____

Please continue on 2nd page

Check any illnesses that you are currently experiencing or have in the past. List pertinent details.

Illness	**Yes**	**Illness**	**Yes**
Cardiac		Neurological	
Gastrointestinal		Reproductive	
Genitourinary		Respiratory	
Hearing		Skin	
Mental Health		Vascular	
Musculoskeletal		Vision	

Additional Health History: _____

_____

_____

Current Medications: List all current medications. Include over-the-counter medications, vitamins and herbal supplements.

Name of Medication/Supplement	**Dose**	**Time(s) of Day Taken**