Name of Care Facility:

KEEP THIS SHEET

HEALTH HISTORY QUESTIONNAIRE FOR EMERGENCY PRE-HOSPITAL CARE PROVIDERS

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	**M** ☐ **F** ☐	**DOB:**
Emergency Contact or POA:		
Phone Number(s):		
Name of Doctor:	**Advance Directive/DNR:** ☐ Yes ☐ No	

Insurance Plan: **ID#:** **Group#:**

PERSONAL HEALTH HISTORY

Infectious Diseases: ☐ Hep C ☐ HIV ☐ TB ☐ Meningitis ☐ MRSA ☐ CDIFF

Current History:	☐ Hypertension	☐ Stroke/TIA
	☐ Diabetes	☐ Cardiac
	☐ CHF/COPD	☐ Dementia/Alzheimers

List any additional current or past medical problems including cancer:

List your prescribed drugs and over-the-counter drugs inlcuding blood thinners

1	8	15
2	9	16
3	10	17
4	11	**Blood Thinners**
5	12	1
6	13	2
7	14	3

Allergies

1	4	7
2	5	8
3	6	9

Do you have trouble walking and use walker, cane or wheelchair? ☐ YES ☐ NO

Are you on Hospice? ☐ YES ☐ NO