Portable Health Record

WYOMING family TO family HEALTH INFORMATION CENTER

Date:	Completed by:	Initials:

Name:		
Nickname:		
Date of Birth:	Gender:	Language:
Parent/guardian name:		
Home address:		
City:	State:	Zip:
Home phone:		
Cell phone:		

Allergies/medications/procedures to avoid	And why:
1.	
2.	
3.	
4.	
5.	

Emergency Contact Information	
Name:	Phone (Home):
Relationship:	Phone (Cell):
Name:	Phone (Home):
Relationship:	Phone (Cell):

Health Care Contacts	
Primary Care Physician:	Phone:
	Emergency Phone:
Specialist/Specialty:	Phone:
	Emergency Phone:
Specialist/Specialty:	Phone:
	Emergency Phone:
Therapist:	Phone:
	Emergency Phone:
Care Coordinator/Case Manager:	Phone:
	Emergency Phone:
Home Care Agency/Social Services:	Phone:
	Emergency Phone:

Portable Health Record

Transportation company/provider:	Phone:
	Emergency Phone:
Other:	Phone:
	Emergency Phone:
Other:	Phone:
	Emergency Phone:

Significant past medical history:
1.
2.
3.
4.

Baseline/abnormal findings:	
Vital signs:	
Respiratory:	Blood pressure:
Weight:	Pulse:
Exam findings:	

Emergency Medial Recommendations:		
Problems/findings	Labs/diagnostic imaging	Treatment

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Pharmacy:	
Pharmacy name:	Phone:
Address:	Fax:
	Other:

Medical Equipment:			
Equipment name	Maker/supplier	Supplies needed	Phone number

Immunizations:				
Are your child's immunizations up to date?		Yes		No
If, no, note the missing vaccinations:				
Attach a copy of the immunization form				

Home care agency/social service needs:	
Agency	Notes
WIC	
Nurse	
Other:	
Other:	

Care plan:			
Condition/issue	Management plan	Person responsible	Status
			• Complete • Ongoing
			• Complete • Ongoing

Health Care Providers and Support

			• Complete • Ongoing
			• Complete • Ongoing

Topics or questions to discuss
1.
2.
3.
4.