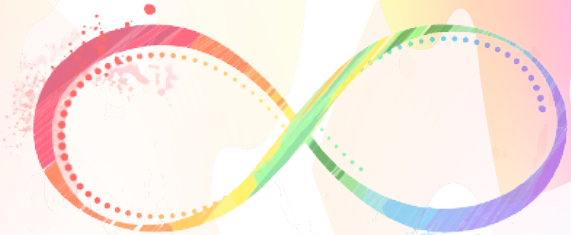
HEALTH PASSPORT



AACOG

Alamo Area Council of Governments

Place photo here

2x2

Call me (nickname):

_____

My information:

First Name: _____

Middle Name: _____

Last Name: _____

Address: _____

_____

Date of Birth: _____

Gender: _____

Family Emergency Contact

First Name: _____

Last Name: _____

Address: _____

Phone #: _____

Relation: _____

What I like

What I don't like

Healthcare Proxy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____

Diagnosis

Blood Type

Allergies

Medications that have been prescribed by my doctors

Information about me

Which language do I prefer?

_____

How do I communicate?

☐ I do not use words ☐ I use gestures ☐ I use words

☐ Communication Device ☐ Sign Language

☐ Other: _____

Do I have a guardian? ☐ Yes ☐ No

Do I need help walking? ☐ Yes ☐ No

Do I need help eating? ☐ Yes ☐ No

Am I hearing impaired? ☐ Yes ☐ No

Am I visually impaired? ☐ Yes ☐ No

Adaptive aids I use:

☐ Prosthetics
☐ Communication Aids
☐ Wheelchair/scooter
☐ Walker/Cane
☐ Eyeglasses
☐ Hearing aids
☐ Vechile Lift
☐ Bathrooom aids

Other: _____

People to support me in my decisions

First Name: _____

Last Name: _____

Phone #: _____

First Name: _____

Last Name: _____

Phone #: _____

First Name: _____

Last Name: _____

Phone #: _____

My Healthcare

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____
Type:_____

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____
Type:_____

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____
Type:_____

Providers/Doctors

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____
Type:_____

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____
Type:_____

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____
Type:_____

My Dental History

My Medical History

How to support me

What is important to me

Notes

Notes

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