Health & Safety *Passport of:*

Paste

Passport

Photo

Here

Distinguishing marks:

In an emergency, whether big or small, first responders such as hospitals must be prepared to meet the needs of the community. California Pacific Medical Center is committed to being here for you in your time of need.

This health passport is designed to help you take an active role in your medical care and can provide your family and health professionals with critical information in an emergency. Keeping this booklet up-to-date will help you provide important information in a moment's notice.

Visit **www.cpmc.org/learning** to learn more about your health. For more information about disaster preparedness go to www.sfgov.org/sfnert.

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Important: This is your personal record of your health history and care received to be used as a reference for medical visits with your primary care physician, as well as other health care providers attending to your needs. Always consult your primary care physician regarding health and immunization considerations.

Permanent Record. Keep in a safe place!

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Personal Information

Legal name

Address

City State Zip

Telephone Telephone

Date of Birth Gender: ☐ Female ☐ Male

Blood Type Rx Factor: ☐ Positive ☐ Negative

Medic-Alert® Bracelet

In case of emergency, notify:

Name

Relationship

Address

City State Zip

Telephone Telephone

Primary Physician/Health Care Provider

Address

City State Zip

Telephone

Medical History

Allergies (medications, food, environmental)

☐ Medication ☐ Food ☐ Other: ______________________

Year: _________ Reaction: ___________________________

☐ Medication ☐ Food ☐ Other: ______________________

Year: _________ Reaction: ___________________________

☐ Medication ☐ Food ☐ Other: ______________________

Year: _________ Reaction: ___________________________

Medical Problems (indicate if you have been diagnosed with the following medical problems):

☐ Alcohol or Drug Addiction
☐ Allergies
☐ Alzheimer's
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Bleeding/Clotting Problems
☐ Bronchitis
☐ Cancer (malignant) Type: ______________________
☐ Chest Pain/Angina
☐ Depression
☐ Diabetes ☐ Type 1 ☐ Type 2
☐ Difficulty Swallowing
☐ Difficulty Urinating
☐ Digestive Problems
☐ Headaches
☐ Hearing Impairment
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Infertility Problems
☐ Irregular Heartbeat
☐ Kidney Disease
☐ Liver Disease
☐ Neurological Disorders
☐ Numbness or Weakness
☐ Respiratory Disease
☐ Seizure/Epilepsy
☐ Sexually Transmitted Infections
☐ Skin Disorder
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Urinary Incontinence
☐ Vision Impairment
☐ Weight Gain (significant)
☐ Weight Loss (unexplained)

Family History

Relative	Serious Illness/ Medical Condition	Cause of Death/ Age at Death
Mother		
Father		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Other		
Other		
Other		
Other		

Hospitalizations

Date	Illness/Injury/Procedure	Hospital	City/State

Vaccinations

Adolescent and Adulthood (19 years and older). Consult with your physician about annual vaccinations.

Pneumococcal	date	date	date	
Hepatitis A	date of dose	date of dose		
Hepatitis B	date of dose	date of dose	date of dose	
Meningococcal	date of dose			
Rubella	date of dose			
Tetanus, Diphtheria Booster (TD Booster, every 10 years)				
Influenza (yearly)				

Diabetic Information for Type 1 Diabetes

Date of Prescription

Type of Insulin	Name of Insulin
Rapid-Acting	
Short-Acting	
Intermediate-Acting	
Long-Acting	
Pre-Mixed /	
Urine Microalbumin	
Eye Exam Date	
Foot Exam Date	
Smoking ☐ Yes ☐ No	

Blood Glucose Target Ranges

Before Meals mmol/L

1-2 hrs. after eating mmol/L

HbA_1c %

Insulin pump user? ☐ Yes ☐ No Type:

Date of Prescription

Type of Insulin	Name of Insulin
Rapid-Acting	
Short-Acting	
Intermediate-Acting	
Long-Acting	
Pre-Mixed /	
Urine Microalbumin	
Eye Exam Date	
Foot Exam Date	
Symptoms when blood sugar low ☐ Yes ☐ No	

Insurance Providers

Insurance Company ________ Type of Coverage ________

Policy/Group No. ________ Telephone ________

Insurance Company ________ Type of Coverage ________

Policy/Group No. ________ Telephone ________

Insurance Company ________ Type of Coverage ________

Policy/Group No. ________ Telephone ________

☐ Medicare ☐ Medicaid I.D. Number ________

Health Care Providers

Physician/Provider ________ Specialty ________

Address ________

City ________ State ____ Zip ____

Telephone ________

Physician/Provider ________ Specialty ________

Address ________

City ________ State ____ Zip ____

Telephone ________

Health Care Providers

Physician/Provider Specialty

Address

City State Zip

Telephone

Physician/Provider Specialty

Address

City State Zip

Telephone

Physician/Provider Specialty

Address

City State Zip

Telephone

Dentist

Address

City State Zip

Telephone

Hospital/Clinic

Address

City State Zip

Telephone

Current Medications

Medication	Reason	Dose	Frequency

Current Medications

Medication	Reason	Dose	Frequency

Current Medications

Medication	Reason	Dose	Frequency

Over-the-Counter and Herbal Medications

Medication	Reason	Dose	Frequency

Blood Pressure

Date	Systolic / Diastolic	Pulse
	/	
	/	
	/	
	/	
	/	
	/	
	/	
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Blood Pressure

Date	Systolic	Diastolic	Pulse
	/		
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Blood Pressure

Date	Systolic / Diastolic	Pulse
	/	
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Cholesterol

Date	LDL (“bad”)	HDL (“good”)	Triglycerides	Total

Weight and Body Mass Index (BMI)

Body Mass Index (BMI) is a tool used to determine if an individual is underweight, overweight or within a healthy weight range. Use the following formula to determine your BMI:

$$\textbf{BMI} = \left(\frac{\text{Weight in Pounds}}{\text{(Height in Inches) x (Height in Inches)}}\right) \text{x } 703$$

Individuals with a BMI below 18.5 is generally considered underweight, a BMI of 18.5–24.9 is generally considered normal, a BMI of 25.0–29.9 is generally considered overweight, and a BMI of 30.0 and above is considered obese.

Height ___________________________

Date	Weight	BMI

Weight and Body Mass Index (BMI)

Height ____________________

Date	Weight	BMI

Date	Weight	BMI

Ophthalmic Prescriptions and Information

Foc Laser: ☐ Yes ☐ No

Eyeglasses Rx		Sphere	Cylinder	Axis	Prism	Base
D.V.	O.D.					
	O.S.					
N.V.	O.D.					
	O.S.					
Remarks					Date	
Provider/Location					Phone	

Contacts	Sphere	Cylinder	Axis	BC	Dia	Brand
O.D.						
O.S.						
Remarks					Date	
Provider/Location					Phone	

	Date		Date		Date		Date
VA		Glauc.		NPDR		Mac Edema	
IOP		Cataract		BDR		PDR	

Advanced Directives

The following advanced directives have been completed and are on file with the firm/registry/individual indicated below.

☐ Power of Attorney for Health Care
☐ Declaration for Mental Health Treatment
☐ Living Will
☐ Do-Not-Resuscitate (DNR) Orders
☐ Other ______________________________

____

Office/Individual ______________________________

Address ______________________________

City ______________________ State ________ Zip ________

Telephone ______________________________

Organ Donation

☐ I give any needed organs, tissues, or parts
☐ I give only the following organs, tissues, or parts:

____

____

My gift (if any) is for the following purposes:

☐ Transplant ☐ Research ☐ Therapy ☐ Education

Signature ______________________________

Date ______________________________

Disaster and Emergency Preparedness

During an earthquake:

- **Drop, Cover, and Hold.** During an earthquake drop to the floor against an interior wall and protect your head and neck with your arms. Avoid exterior walls, windows, hanging objects and appliances.
- You are safer under a table during an earthquake than in a doorframe.
- Do not go outside until well after the shaking stops.
- When outside, move to a clear area avoiding buildings, power lines, trees and other hazards, assume all fallen power lines are live.

Basic to do's after an earthquake:

1. Wear heavy soled shoes to avoid cuts from broken glass.
2. Check for injuries
3. Check for potential safety problems during after shocks.
4. Make a safety inspection
   –Check gas, water and sewage breaks
   –Look for downed electrical lines and shorts, assume all power lines are live
   –Clean up dangerous spills
   –Turn on radio and listen for instructions
   –Use telephone only in emergencies
   –Inspect chimney
   –Look for cracks around foundation

Family Reunification Plan:

Family Emergency Contact (preferably out of state):

Name ______________________ Telephone ______________________

Name ______________________ Telephone ______________________

Family meeting location (address or intersection):

____

Other important contacts:

Name Telephone

Name Telephone

Name Telephone

Name Telephone

Reunification Plan:

If you or someone you are with needs medical attention and you are unable to get through to 911, you or someone else will need to go to your neighborhood predetermined check in location established by NERT. At the site a HAMM radio operator will send a message to the communications station for the County Emergency Medical Service who will then dispatch an ambulance to your location as soon as possible.

Neighborhood Emergency Response Team (NERT) pre-determined check in location:

Notes and Questions to Ask Your Doctor

About California Pacific Medical Center

California Pacific Medical Center is one of the largest private, not-for-profit, teaching medical centers in Northern California and a Sutter Health affiliate. We provide access to leading-edge medicine while delivering the best possible personalized care.

Visit **www.cpmc.org/learning** to learn more about your health.

415-600-6000
www.cpmc.org