Print Form

LIBRARY OF CONGRESS - INDIVIDUAL HEALTH PROFILE

This is a confidential health inquiry that will only be used by doctors and nurses in the event of a medical crisis. Voluntary completion of this inquiry may prove valuable for you in the event of sudden illness.

Name (Last, First, Middle Initial)	Date of Birth (Mo./Day/Yr.)	Social Security No.	Today's Date (Mo./Day/Yr.)
Home Address			Home Phone No.
Division/Office Name	Work Phone Ext.	Supervisor's Name	Supervisor's Phone Ext.
Health Insurance Name	Policy Number	Contact Name	Phone No.
Emergency Contact Person	Home Phone No.	Work Phone No.	Other No
Address			Relationship
Doctor's Name			Phone No.

I. CURRENT HEALTH PROBLEMS:

YES	NO	
☐	☐	Back Problems
☐	☐	Glaucoma
☐	☐	High Blood Pressure
☐	☐	Heart Disease
☐	☐	Diabetes (sugar)
☐	☐	Cancer
☐	☐	TB
☐	☐	Bleeding Problem
☐	☐	Seizures or Convulsions
☐	☐	Drug or Alcohol Problems
☐	☐	Other: _____

YES	NO	
☐	☐	Emotional or Mental Problems
☐	☐	Lung Problem
☐	☐	Stomach Problem
☐	☐	Kidney Problem
☐	☐	Hearing Loss
☐	☐	Hepatitis A, Date: _____
☐	☐	Hepatitis B, Date: _____
☐	☐	Hepatitis C, Date: _____
☐	☐	Hepatitis: _____, Date: _____
☐	☐	Vision Problems, Explain: _____
☐	☐	Disability, Explain: _____

II. ALLERGIES: ☐ NO ☐ YES. If "YES", explain below. If needed, continue in Section IX on verso.

MEDICATION	TYPE OF REACTION	ENVIRONMENTAL	TYPE OF REACTION

III. PRESCRIPTION MEDICATION: ☐ NO ☐ YES. If "YES", explain below. If needed, continue in Section IX on verso.

MEDICATION	DOSAGE	FREQUENCY	START DATE

Continued on Verso

LIBRARY OF CONGRESS - INDIVIDUAL HEALTH PROFILE (CONTINUED)

Name (Last, First, Middle Initial)	Date of Birth (Mo./Day/Yr.)	Social Security No.	Today's Date (Mo./Day/Yr.)

IV. OVER THE COUNTER MEDICATION: ☐ NO ☐ YES. If "YES", explain below. If needed, continue in Section IX.

MEDICATION	DOSAGE	FREQUENCY	START DATE

V. HERBAL AND/OR NUTRITIONAL SUPPLEMENTS: ☐ NO ☐ YES. If "YES", explain below. If needed, continue in Section IX.

MEDICATION	DOSAGE	FREQUENCY	START DATE

VI. SURGERY: ☐ NO ☐ YES. If "YES", explain below. If needed, continue in Section IX.

TYPE	DATE	TYPE	DATE

VII. CURRENT HABITS:

YES	NO		YES	NO	
☐	☐	Cigarettes - less than 1/2 pack per day	☐	☐	Alcohol - less than 2 oz., or 2 cans of beer per week
☐	☐	Cigarettes - between 1/2 and 2 packs per day	☐	☐	Alcohol - between 3 to 6 oz., or 3 to 6 cans of beer per week
☐	☐	Cigarettes - more than 2 packs per day	☐	☐	Alcohol - more than 6 oz. or 6 cans of beer per week
☐	☐	Cigars	☐	☐	Cocaine
☐	☐	Pipe	☐	☐	Heroin
☐	☐	Chewing Tobacco	☐	☐	Marijuana
☐	☐	Decaffeinated Coffee - More than 2 cups per day	☐	☐	PCP
☐	☐	Regular Coffee - More than 2 cups per day	☐	☐	Other:

VIII. SELF CARE	MONTH	YEAR	SELF CARE	MONTH	YEAR
A. LAST VISIT TO ANY PHYSICIAN			F. LAST CHEST X-RAY		
B. LAST PHYSICAL EXAMINATION			G. LAST TETANUS INJECTION		
C. LAST DENTAL EXAMINATION			H. LAST HEPATITIS (A) SERIES		
D. LAST PAP SMEAR			I. LAST HEPATITIS (B) SERIES		
E. LAST MAMMOGRAM			J. OTHER:		

IX. ADDITIONAL INFORMATION