

# H

# My Health Passport

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If you are a **health care professional** who will be helping me,

**PLEASE READ THIS**

**before** you try to help me with my care or treatment.



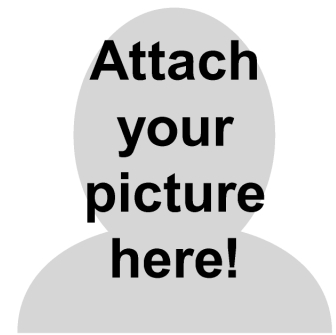
My full name is: \_\_\_\_\_

I like to be called: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

My primary care physician: \_\_\_\_\_

Physicians phone number: \_\_\_\_\_



This passport has important information so you can better support me when I visit/stay in your hospital or clinic.

Please keep this with my other notes, and where it may be easily referenced.

My signature: \_\_\_\_\_

Date completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

You can talk to this person about my health: \_\_\_\_\_

Phone number: \_\_\_\_\_

Relationship: \_\_\_\_\_



**I communicate using:** (e.g. speech, preferred language, sign language, communication devices or aids, non-verbal sounds, also state if extra time/support is needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**My brief medical history:** (include other conditions (e.g. visual impairment, hearing impairment, diabetes, epilepsy) past operations, illnesses, and other medical issues)

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**My current medications are:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



**When I take my medication, I prefer to take it:** (e.g. with water, with food)

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**I am allergic to:** (list medications or foods, e.g. penicillin, peanuts)

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**If I am in pain, I show it by:** (also note if I have a low/high pain tolerance)

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**If I get upset or distressed, the best way you can help is by:** (e.g. play my favorite music)

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**How I cope with medical procedures:** (e.g. how I usually react to injections, IVs, physical examinations, x-rays, oxygen therapy)  also note procedures never experienced before or in recent years)

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**My mobility needs are:**  
(e.g. whether I can transfer independently, devices I use, pressure relief needed)

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**When getting washed and dressed, you may assist me by:**

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**When drinking, you may assist me by:**

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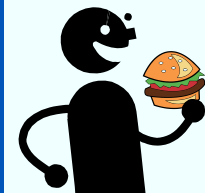
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**When eating, you may assist me by:**

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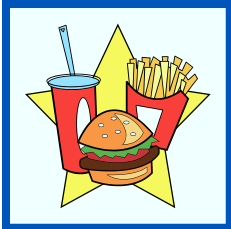
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**My favorite foods and drinks are:**

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**I do not like to eat or drink the following:**

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**I am very sensitive to:** (specific sights, sounds, odors, textures/fabric, etc. that I really dislike, e.g. fluorescent lights, thunderstorms, bleach, air freshener)

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**Things I like to do that will help pass the time:**

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**How to make future/follow-up appointments easier for me:**

(e.g. give me the first/last appointment of the day, allow extra time for the appointment, let me visit before my appointment, give information to my caregiver, etc.)

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**For patients who are their own guardian/have capacity:**

**Do you have (check all)**

- an advance directive
- a health care agent
- a living will
- a POLST form?

If so please bring a copy of each document to the hospital

**If while you are in the hospital you can't breathe on your own, do you want a machine to help breathe for you? (Mechanical ventilation)**

- Do you not want it at all?
- Do you want a trial to see if it is helping?
- Do you want it for as long as it is needed?

**If while you are in the hospital your heart stops, do you want your doctor to try to restart it with pushing on your chest, medications, and electric shocks? (Resuscitation)**

- yes  no

**If you can't eat or drink like you normally do, do you want liquid food and water to be given to you through a tube to your stomach or in a vein? (Artificial nutrition/hydration)**

- yes  no