Daily Companion®

PERSONAL HEALTH RECORD (PHR)

Form Creation

Please use this form to help create and expedite your health profile and submittal to your device.

Personal health Information as of date:_____

Title: _____ First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Date of Birth: _____ (Format as MM/DD/YY) Gender: _____ Male _____ Female

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____-_____ Country: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Weight: _____ (lbs.) Height: (___Feet ___Inches) Eye Color: _____ Hair Color: _____

Ethnicity (Circle): [ ] American Indian [ ] African American [ ] Hispanic or Latino [ ] Pacific Islander [ ] White

[ ] Mix-Race [ ] Other

DNR (Do Not Resuscitate) on File: [ ] If checked then fill in the lines below where it's located or who has the document:

_____

_____

Donor (Check if donor): [ ] Account Manager (This is auto-filled by Daily Companion)

For Manager: How long before being notified of device non-use (Select One): [ ] None [ ] 24 - 36 [ ] 48 hours

Alert Message (State what should be said in Text Message): _____

SS#_____-_____-_____ (will only show last four) Language Spoken: _____

Martial Status (Chose One): [ ] Divorced [ ] Married [ ] Never Married [ ] Separated

[ ] Significant Other/Partner [ ] Single [ ] Widowed

Allergies – Reactions

What type of allergy or reaction do you have?: _____
(Example: penicillin, peanuts, cat dander)

What type of symptoms do you have?: _____

(Example: cramping, pain, bloating)

Special Notes:_____

Does this allergy affect you now? [ ] Yes – Active [ ] No – Inactive at this time

Date started: _____ ***(Best guess)*** Date ended:_____ ***(Optional)***

How severe is this allergy? [ ] Low –Little or no medical treatment [ ] Mild – Some medical treatment

[ ] Severe – May require immediate medical treatment

What type of allergy or reaction do you have?: _____

What type of symptoms do you have?: _____

Special Notes:_____

Does this allergy affect you now? [ ] Yes – Active [ ] No – Inactive at this time

Date started: _____ Date ended:_____

How severe is this allergy? [ ] Low –Little or no medical treatment [ ] Mild – Some medical treatment

[ ] Severe – May require immediate medical treatment

What type of allergy or reaction do you have?: _____

What type of symptoms do you have?: _____

Special Notes:_____

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Date started: _____ Date ended:_____

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What type of symptoms do you have?: _____

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What type of symptoms do you have?: _____

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Date started: _____ Date ended:_____

How severe is this allergy? [ ] Low –Little or no medical treatment [ ] Mild – Some medical treatment

[ ] Severe – May require immediate medical treatment

Emergency Contacts

Title: _____ First Name: _____ Last Name: _____ Suffix: _____

Relationship (Select one): [ ] Children [ ] Daughter-in-law [ ] Family [ ] Friend [ ] Other [ ] Self

[ ] Sibling [ ] Son-in-law [ ] Spouse

Contact Phone: _____ Contact Fax: _____

Cell Phone: _____ Email: _____

[ ] Check this if you want this personal to receive a notification of your emergency from the call center

---

Title: _____ First Name: _____ Last Name: _____ Suffix: _____

Relationship (Select one): [ ] Children [ ] Daughter-in-law [ ] Family [ ] Friend [ ] Other [ ] Self

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Contact Phone: _____ Contact Fax: _____

Cell Phone: _____ Email: _____

[ ] Check this if you want this personal to receive a notification of your emergency from the call center.

Fax - Fax number where your health profile would be sent

Fax Name: _____ Fax Number: _____

Fax Extension: _____

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Fax Name: _____ Fax Number: _____

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Immunizations

Vaccine: _____ Date Given: _____ Expired Date: _____

(Example: shingles vaccine, measles/mumps/rubella) ***(Best guess)*** ***(Best guess)***

Vaccine: _____ Date Given: _____ Expired Date: _____

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Vaccine: _____ Date Given: _____ Expired Date: _____

Vaccine: _____ Date Given: _____ Expired Date: _____

Vaccine: _____ Date Given: _____ Expired Date: _____

Insurance

Select Insurance Status: [ ] Primary Health Insurance [ ] Supplemental Health Insurance

Insurance type: [ ] Affordable Care Act [ ] FECA [ ] Group Health Insurance [ ] Medicaid [ ] Tricare/Champus
[ ] VHA [ ] Other: _____

Provider: _____

Plan Name: _____

Plan ID: _____

Group Number: _____

Policy ID: _____

Insurance Phone: _____ Ext: _____ Fax: _____

Coverage start date: _____ Coverage end date: _____

Beneficiary: _____

Select Insurance Status: [ ] Primary Health Insurance [ ] Supplemental Health Insurance

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Insurance type: [ ] Affordable Care Act [ ] FECA [ ] Group Health Insurance [ ] Medicaid [ ] Medicare
[ ] Tricare/Champus [ ] VHA [ ] Other: _____

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Policy ID: _____

Insurance Phone: _____ Ext: _____ Fax: _____

Coverage start date: _____ Coverage end date: _____

Beneficiary: _____

Medical History

This provides paramedics and emergency responders an insight to your personal health information and status. Only one health status is allowed in your profile. When you update your profile, the previous profile will be deleted.

Select Blood Type: [ ] A+ [ ] A- [ ] AB+ [ ] AB- [ ] B+ [ ] B- [ ] 0+ [ ] O-

Blood Pressure: [ ] Diastolic [ ] Systolic Pulse/Heart Rate: _____bpm

Smoker: [ ] Yes [ ] No

Drinker (Select One): [ ] 3-4 times/week [ ] 2-4 times/month [ ] Monthly or less [ ] Never [ ] Yes

Health Status (Tell us how you feel overall): [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Injury / Illness

Select either -

Chronic Illness: ____

Or

Injury / Illness Type: ____

Consultation Date: ______________________ Physician Name: ____

Physician Phone: ________________________ Phone Extension: _________ Physician Fax: ________________________

Physician Emergency Number: ________________________ Email: ____

Select either -

Chronic Illness: ____

Or

Injury / Illness Type: ____

Consultation Date: ______________________ Physician Name: ____

Physician Phone: ________________________ Phone Extension: _________ Physician Fax: ________________________

Physician Emergency Number: ________________________ Email: ____

Select either -

Chronic Illness: ____

Or

Injury / Illness Type: ____

Consultation Date: ______________________ Physician Name: ____

Physician Phone: ________________________ Phone Extension: _________ Physician Fax: ________________________

Physician Emergency Number: ________________________ Email: ____

Operation/Surgery or Treatment

Operation/Surgery/Treatment: _____

_____

_____

Admission Date: _____ Physician Name: _____

Physician Phone: _____ Phone Extension: _____ Physician Fax: _____

Physician Emergency Number: _____ Email: _____

Operation/Surgery/Treatment: _____

_____

_____

Admission Date: _____ Physician Name: _____

Physician Phone: _____ Phone Extension: _____ Physician Fax: _____

Physician Emergency Number: _____ Email: _____

Operation/Surgery/Treatment: _____

_____

_____

Admission Date: _____ Physician Name: _____

Physician Phone: _____ Phone Extension: _____ Physician Fax: _____

Physician Emergency Number: _____ Email: _____

Medication

Medication Name: _____ Generic Name: _____

Status?: [ ] Yes – Active [ ] No – Inactive at this time

Date it started _____ Date it ended _____

Dosage Type: _____ Dosage Size: _____ Dosage Unit: _____

Delivery Method: _____ Dosage Count: _____ Dosage Frequency: _____

Taken When? _____ Schedule Time: _____

Drug I.D. _____ Prescription Date: _____

Physician Name: _____ Physician Phone: _____

Dispense Date: _____ Quantity: _____ Refills: _____

Pharmacy name and phone number will be populated when you fill out the Pharmacy section

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Pharmacy

Pharmacy Name: _____ Client Account ID: _____

Client Email: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____-_____ Country: _____

Pharmacy Phone: _____ Phone Extension: _____ Pharmacy Fax: _____

Pharmacy Email: _____ Pharmacy Website: _____

Pharmacy Name: _____ Client Account ID: _____

Client Email: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____-_____ Country: _____

Pharmacy Phone: _____ Phone Extension: _____ Pharmacy Fax: _____

Pharmacy Email: _____ Pharmacy Website: _____

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Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____-_____ Country: _____

Pharmacy Phone: _____ Phone Extension: _____ Pharmacy Fax: _____

Pharmacy Email: _____ Pharmacy Website: _____

Phone Book Entries

Contact Name:_____

Phone Number: _____ Phone Extension: _____

[ ] Yes, I want this person to be contacted by Daily Companion if I have an emergency.

[ ] No, I do not want this person to be contacted by Daily Companion if I have an emergency.

Contact Name:_____

Phone Number: _____ Phone Extension: _____

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Physician(s)

Primary Physician: [ ] Yes [ ] No (The system allows for 1 primary physician. It will also appear in the Phone Book)

Physician Name: _____ Practice Name: _____

Specialty: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____-_____ Country: _____

Physician Phone: _____ Phone Extension: _____ Physician Fax: _____

Physician Emergency Number: _____ Email: _____

Primary Physician: [ ] Yes [ ] No (The system allows for 1 primary physician. It will also appear in the Phone Book)

Physician Name: _____ Practice Name: _____

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