

HP ADULT QUESTIONNAIRE: Page 2:

7. ORGAN DONOR: NO YES * * If YES make sure you're a bona fide donor including organ donor registry card and family agreement

8. PERSONAL MEDICAL HISTORY:

List conditions such as diabetes, high blood pressure, cancer, kidney disease, asthma, psychological conditions, Hepatitis C, heart attack or heart disease, visual, speech, or hearing conditions, AIDS, polio, birth defects, etc.

9. PERSONAL SURGICAL HISTORY:

List conditions such as heart surgery, organ surgery, bone - (arms, legs, ribs, skull, etc.) surgeries, dental surgery, hysterectomy, prostate surgery, gall bladder surgery, appendectomy, cosmetic surgery, bariatric surgery, etc.

9. FAMILY'S HEALTH HISTORY:

SIBLING(S): AGE(S): LIVING = (L) DECEASED* = (D*)

MOM: AGE: LIVING: DECEASED*: DAD: AGE: LIVING: DECEASED*:

* If deceased - please include cause of death for example - Heart attack, Stomach cancer, Lung cancer, Renal failure, TB, Auto accident, Rare condition, Natural causes, Unknown, etc.

10. MEDICAL INSURANCE:

NAME OF INSURANCE COMPANY:	TYPE OF COVERAGE:	ACCT NUMBER: (Optional)

11. LIVING WILL: No: Yes: *

MEDICAL DURABLE POWER OF ATTORNEY: No: Yes: *

ADVANCED DIRECTIVES INFORMATION: No: Yes: *

DNR STATUS: No: Yes: *

* If yes, please submit a copy for your HPI records

12. For any additional important medical, surgical, congenital or genetical condition not covered or mentioned in the above sections - please use separate sheet or page 3 of this Questionnaire.

Signature: _____

Please e-mail completed form to:
support@hpicenter.com or
louzurita@yahoo.com
or mail to:
HPICENTER.COM
7151 Woodlake Estates 28,
San Antonio, Texas 78218