



**My favorite foods and drinks are:**

---

---

---

---

---



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

---

---

---

---

---



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

---

---

---

---



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

---

---

---

---



**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.)

---

---

---

---



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

---

---

---

---

---

---



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

---

---

---

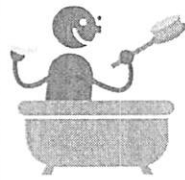
---

---

---

---

---



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

---

---

---

---

---

---

---

---



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

---

---

---

---

---

---

---

---



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

---

---

---

---

---

---

---

---



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

---

---

---

---

---



**My current medications are:**

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



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

---

---

---

---

---



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

---

---

---



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

---

---

---

---

---



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

---

---

---

---

---

# H

# My Health Passport

# H



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: \_\_\_\_\_

Physician's phone number: \_\_\_\_\_

**Attach  
your  
picture  
here!**

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.

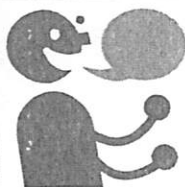
My signature: \_\_\_\_\_

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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_