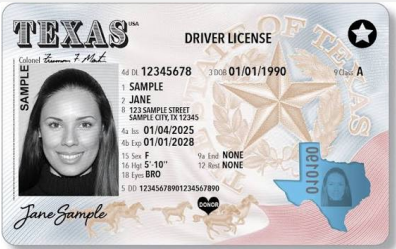
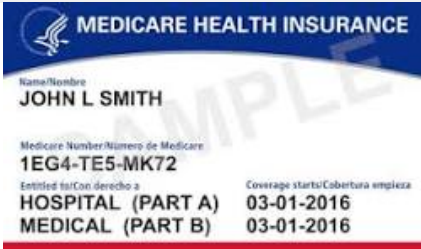


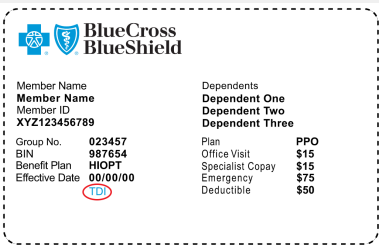
Texas Drivers Licence



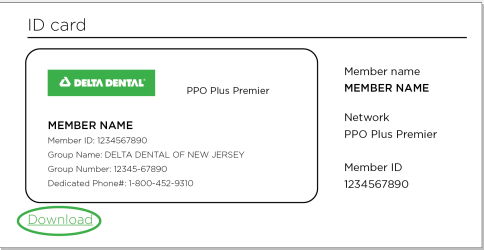
Medicare Card



Medical Insurance



Dental Card



Emergency Contacts

First Name	Last Name	Phone	Type	Relationship
Tom	Jones	123-456-7890	cell	Brother
Bob	Smith	123-456-7890	cell	Father

Doctors / Providers

Type	First Name	Last Name
Cardio	Michael	Smith
Optometry	Elan	Eye

Medications

Name	Dosage	Frequency	Prescribing Doctor	Notes	Start Date	End Date
minoxidil 2.5 mg tablet	TAKE ONE TABLET BY MOUTH ONCE DAILY.				0000-00-00	0000-00-00

Medications Cont.

Name	Dosage	Frequency	Prescribing Doctor	Notes	Start Date	End Date
meloxicam 15 mg tablet	TAKE 1 TABLET 15 MG BY MOUTH AS N...			for pain	2001-01-01	0000-00-00

Medications Cont.

Name	Dosage	Frequency	Prescribing Doctor	Notes	Start Date	End Date
atorvastatin 20 mg tablet	Take 20 mg every day by oral route.	1			0000-00-00	0000-00-00

Major Events

Event/Condition	Date of Event	Note
Polyp of colon	2024-03-15	active

Surgeries

Surgical Event	Date of Event	Note
Eye Lens Replacement	2001-01-01	

Major Procedures

Procedure Event	Date of Event	Note
CT, chest, w/o contrast	2024-11-24	Diagnostic Report CT Chest WO contrast CT, chest, w/o contrast
CT, angiogram, coronary arteries, w/ contrast	2024-11-24	Diagnostic Report CT, angiogram, coronary arteries, w/ contrast

Vaccinations

Vaccine Type	Date of Event	Note
Tdap (Adacel) 7yrs+	2019-02-11	
COVID-19, mRNA, LNP-S, PF, 100 mcg/0.5 mL dose (Moderna)	0000-00-00	
Anthrax vaccine, for SC use	2001-01-01	

Family History

Date	Relationship	Condition	Note
2002-01-01	Father	Heart attack	
2001-01-01	Mother	Auto imune	

Laboratory Test Results

Lab Results				
Group	Test	Date	Result	OOR
lipid panel, standard	cholesterol, total	2025-05-01	154 mg/dL	No
lipid panel, standard	HDL cholesterol	2025-05-01	45 mg/dL	Yes
lipid panel, standard	triglycerides	2025-05-01	77 mg/dL	No
HEMOGLOBIN A1C	GLYCATED HEMOGLOBIN	2222-01-01	5.2 %	
General Lab	WHITE BLOOD COUNT	2019-02-11	4.8 k/mm3	
General Lab	GLUCOSE	2019-02-11	73 mg/dL	
General Lab	GLYCATED HEMOGLOBIN	2017-10-05	5.2 %	
General Lab	25-HYDROXYVIT D TOT	2017-10-05	44 ng/mL	
General Lab	COLOR, URINE	2017-10-05	LIGHT YELLOW	
General Lab	TOTAL PROTEIN	2017-10-05	7.2 g/dL	
General Lab	CHOLESTEROL LEVEL	2017-10-05	210 mg/dL	
General Lab	WHITE BLOOD COUNT	2017-10-05	5.8 k/mm3	
General Lab	GLUCOSE	2017-10-05	89 mg/dL	

Vital Signs History

Vitals Log		
Vital	Date	Result
BMI Percentile	2022-12-08	24
BMI	2022-12-08	33.2

Appointments & Medical Records

Date	Type	Reason	Notes
2026-05-04	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; 40-64 YEARS		OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 30-39 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER. BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT (EG, DEPRESSION INVENTORY, ATTENTION-DEFICIT/HYPERACTIVITY DISORDER [ADHD] SCALE), WITH SCORING AND DOCUMENTATION, PER STANDARDIZED INSTRUMENT
2022-12-08	Annual Visit	3 month f/u	AUDIOMETRY, AIR

Health Care Proxy Documents

Proxy Page 1

Health Care Proxy

(1) I, (1)(1)

hereby appoint

 (name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) **Optional: Alternate Agent**

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint

 (name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

NO ARTIFICIAL NUTRITION

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

Health Care Proxy Page 2

(5) **Your Identification** (in person only)

Your Name

Your Signature

Date

Your Address

(6) **Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues

☐ Limitations

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature

Date

(7) **Statement by Witnesses** (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date

Date

Name of
(print)

Name of Witness
(print)

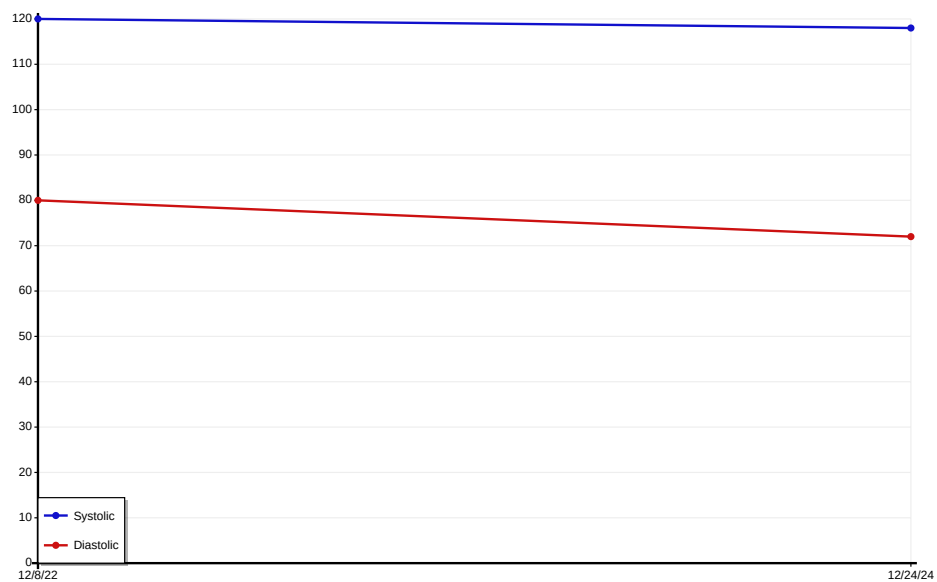
Signature

Signature

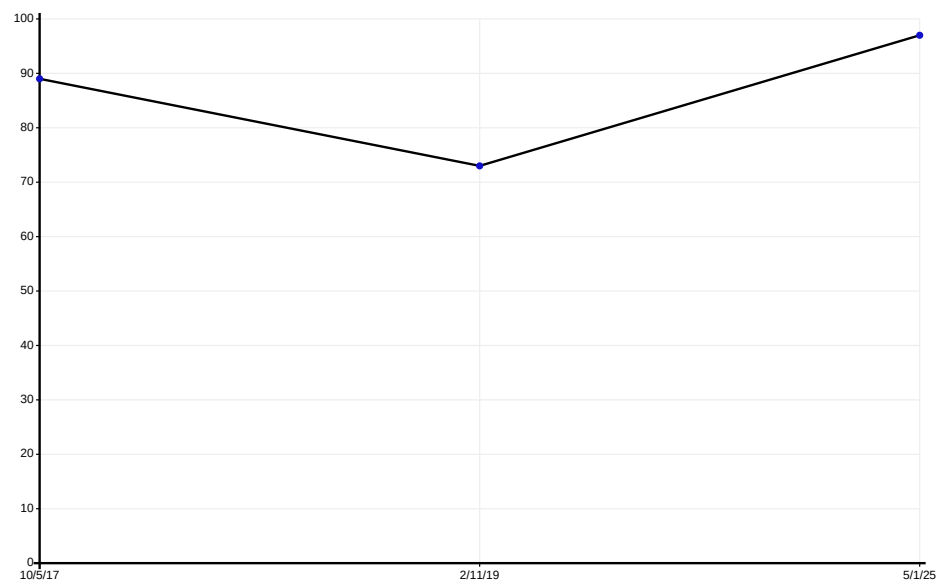
Address

Address

Blood pressure



glucose



Heart Rate

