

KEEP INFORMATION UP TO DATE!!

Review At Least Every Six Months! Use pencil for ease in making changes

MEDICAL DATA REVIEWED AS OF _____ MO. _____ YR.

Name: _____ Sex:
 M F

Address: _____

Primary Doctor: _____ Ph #: _____

Specialist: _____ Ph #: _____

EMERGENCY CONTACTS

Name: _____ Relationship: _____

Home Ph #: _____ Cell Ph #: _____

Name: _____ Relationship: _____

Home Ph #: _____ Cell Ph #: _____

MEDICAL DATA

Special Conditions/Remarks: _____

Medical Problems	Medication	Dosage	Frequency

Date of last: Tetanus shot: _____ Flu shot: _____

Pneumonia shot: _____

Pharmacy: _____ Ph #: _____

Date of Birth: _____ Soc Sec #: _____

Blood Type: _____ Religion: _____

Health Care Proxy on file at: _____

Living Will on file at: _____

Use pencil for ease in making changes

Recent Surgery:

Date:

Do you have an EMS-NO CPR Directive? YES NO
DNR form? YES NO Where are they located?

MEDICAL CONDITIONS

Check All That Exist

- | | |
|--|--|
| <input type="checkbox"/> No Known Medical Conditions | <input type="checkbox"/> Heart Valve Prosth. |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hemolytic Anemia |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Laryngectomy |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cardiac Dysrhythmia | <input type="checkbox"/> Lymphomas |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Memory Impaired |
| <input type="checkbox"/> Chronic Obstructive Pulm. Disease | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Glaucoma | Other _____ |
| <input type="checkbox"/> Hearing Impaired | _____ |

ALLERGIES

- | | | |
|--|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Morphine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Environmental | <input type="checkbox"/> Novocaine | _____ |
| <input type="checkbox"/> Horse Serum | <input type="checkbox"/> Penicillin | _____ |

MEDICAL INSURANCE

Med Ins Co:

Policy #:

Other Med Ins Co:

Policy #:

Medicaid #:

Medicare #: