KEEP INFORMATION CURRENT
Review at least every six months

Medical information reviewed on: Mo. Yr.

Name: ______________________________

Date of Birth: ______________ Sex: M F Blood Type: ________

Address: ______________________________

____

Doctor: ______________________ Phone #: ____________

Preferred Hospital: ______________________________

☐ Health Care Proxy on File There ☐ Living Will on File There

EMERGENCY CONTACTS

Name: ______________________ Phone #: ____________

Address: ______________________________

Name: ______________________ Phone #: ____________

Address: ______________________________

MEDICAL INFORMATION

Medication	Dosage	Frequency

Pharmacy: ______________________ Phone #: ____________

Addition information on back – Use pencil to make updating easier

Recent Surgeries Date

____

____

____

Comfort Care, DNR, or EMS No CPR Directive?

☐ Yes ☐ No Location: ______________________

MEDICAL HISTORY

- ☐ No medical history/otherwise healthy
- ☐ Abnormal EKG
- ☐ Adrenal Insufficiency
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cardiac Dysrhythmia
- ☐ Cataracts
- ☐ Clotting Disorder
- ☐ Dementia ☐ Alzheimer's
- ☐ Diabetes: ☐ Insulin ☐ Non-insulin
- ☐ Eye surgery
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Valve Replacement
- ☐ Hemodialysis
- ☐ Hemolytic Anemia
- ☐ Hepatitis Type ____
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Memory Impairment
- ☐ Myasthenia Gravis
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke/CVA ☐ TIA
- ☐ Tuberculosis
- ☐ Vision Impaired

☐ Other: ______________________________

ALLERGIES

- ☐ No known Allergies
- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocain
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-ray/IVP Dye

☐ Environmental: ______________________________

Other: ______________________________

INSURANCE

Med. Ins. Co: ______________________ Policy: ____________

Med. Ins. Co: ______________________ Policy: ____________

Medicaid: ______________ Medicare: ______________

Additional information on front – Use pencil to make updating easier