***Review* At Least Every Six Months !**

MEDICAL DATA REVIEWED AS OF ___ MO. ___ YR.

Name: Sex: M F

Address:

Doctor: Phone #:

Doctor: Phone #:

EMERGENCY CONTACTS

Name: Phone #:

Address:

Name: Phone #:

Address:

MEDICAL DATA

Special Conditions/Remarks: Use pencil for ease in making changes.

Medical Problems	Medication	Dosage	Frequency

Pharmacy: Phone:

Date of Birth: Soc Sec #:

Blood Type: Religion:

Health Care Proxy on file at:

Living Will on file at:

Recent Surgery: **Date:**

Do you have an EMS-NO CPR Directive or a DNR form ?
YES ☐ NO ☐ Where is it located ?

MEDICAL CONDITIONS

Check all that exist

( ) No known medical conditions
( ) Abnormal EKG
( ) Adrenal Insufficiency
( ) Angina
( ) Asthma
( ) Bleeding Disorder
( ) Cardiac Dysrhythmia
( ) Cataracts
( ) Clotting Disorder
( ) Coronary Bypass Graft
( ) Dementia( ) Alzheimer's( )
( ) Diabetes/Insulin Dependent
( ) Eye Surgery
( ) Glaucoma
( ) Hearing Impaired
( ) Heart Valve Prosthesis
( ) Hemodialysis
( ) Hemolytic Anemia
( ) Hypertension
( ) Hypoglycemia
( ) Laryngectomy
( ) Leukemia
( ) Lymphomas
( ) Memory Impaired
( ) Myasthenia Gravis
( ) Pacemaker
( ) Renal Failure
( ) Seizure Disorder
( ) Sickle Cell Anemia
( ) Stroke
( ) Vision Impaired
Other _____

ALLERGIES

( ) Aspirin
( ) Barbiturate
( ) Codeine
( ) Demerol
( ) Environmental
_____
_____
( ) Horse Serum
( ) Insect Stings
( ) Latex
( ) Lidocaine
( ) Morphine
( ) Novocaine
( ) Penicillin
( ) Sulfa
( ) Tetracycline
( ) X-Rays Dyes
( ) No Known Allergies
( ) Other _____
_____
_____

MEDICAL INSURANCE

Med Ins Co:

Policy #:

Other Med Ins Co:

Policy #:

Medicaid #: Medicare #: