



EMERGENCY MEDICAL INFORMATION



Name:	Date:
Address:	
City:	Zip Code:
Home Phone: ()	Cell Phone: ()
Date of Birth: / /	Age:
Social Security Number:	

Medical History

Please check any medical conditions that apply.

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> GERD/Acid Reflux |

Please list any recent surgeries or additional medical history below:

Family Physician/Specialist:

Preferred Hospital:

Medications: Please list all medications below or include a printout from your pharmacist.

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Please list below any allergies to medications or food.

Advanced Directives: Please attach any applicable paperwork (i.e., DNR) Yes No

Emergency Contact Information:

Name:	Name:
Relationship:	Relationship:
Phone:	Phone:
Address:	Address:
City/State/Zip:	City/State/Zip