

MEDICAL DATA REVIEWED AS OF _____

Name: _____ Sex: ☐ M ☐ F

Address: _____

Doctor: _____ Phone #: _____

Preferred Hospital: _____

EMERGENCY CONTACTS

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

MEDICAL DATA

Special Conditions/Remarks: _____

Medication	Dosage	Frequency

Pharmacy: _____ Phone #: _____

Date of Birth: _____

Blood Type: _____ Religion: _____

Health Care Proxy on file at: _____

Living Will on file at: _____

SEE BACK OF CARD FOR ADDITIONAL INFORMATION

Recent Surgery/Date:

I have an EMS-NO CPR Directive or a DNR form:

YES

NO

Where?

MEDICAL CONDITIONS

Check all that exist

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

ALLERGIES

Aspirin	Insect Stings	Penicillin
Barbiturate	Latex	Sulfa
Codeine	Lidocaine	Tetracycline
Demerol	Morphine	X-Ray Dyes
Horse Serum	Novocaine	No Known Allergies
Environmental:		
Other:		

MEDICAL INSURANCE

Insurance Co:

Policy #:

Other Insurance:

Policy #:

Medicaid #:

Medicare #:
