Medical Data Form

KEEP INFORMATION UP TO DATE

Name: ______________________________________ Male Female

Address: ____________________________________ Date of Birth: ______________

EMERGENCY CONTACTS

	Contact #1	Contact #2	Contact #3
Name			
Address			
Phone			
Relation			

MEDICAL DATA

MEDICAL DATA REVIEWED AS OF _____ Month _____ Year

Doctor: _______________________________ Phone #: ______________________

Preferred Hospital: ______________________ Blood Type: ____

Special Conditions/Remarks:

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MEDICATION:

Medication	Dosage	Frequency

RECENT SURGERIES

Date of Surgery | Type of Surgery | Notes

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HEALTH CARE PROXY

Location of Proxy Documents: ____

Living Will on File At: ____

Religion: ____________

EMERGENCY MEDICAL SERVICES (EMS) PREFERENCES

Do you have an EMS-NO DNR Form: Yes No

Location of DNR Document: ____

MEDICAL CONDITIONS
Check all that apply

No known medical conditions
Abnormal EKG
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
High Blood Pressure (Hypertension)
Hypoglycemia
Laryngectomy
Leukemia
Lymphomas
Memory Impaired
Myasthenia Gravis
Pacemaker
Renal Failure
Seizure Disorder
Sickle Cell Anemia
Stroke
Vision Impaired

Allergies:

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

Environmental: ____

Other: ____

MEDICAL INSURANCE INFORMATION

Insurance Provider: ____

Policy Number: __________________________ Group Number: __________________________

Other Medical Insurance Provider ____

Medicaid #: __________________________________ Medicare #: __________________________

ADDITIONAL NOTES

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