

*Key Information*

NAME		
ADDRESS		
DATE OF BIRTH	/	/
SEX	Female	Male

Emergency Contacts

NAME	RELATION
ADDRESS	PHONE

NAME	RELATION
ADDRESS	PHONE

Do you have an EMS-NO CPR Directive or DNR form?

YES! It can be found at: _____ **NO**

Medical Information - Allergies

<input type="checkbox"/> NO KNOWN ALLERGIES	<input type="checkbox"/> HORSE SERUM	<input type="checkbox"/> NOVOCAINE
<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> INSECT STINGS	<input type="checkbox"/> PENICILLIN
<input type="checkbox"/> BARBITUATE	<input type="checkbox"/> LATEX	<input type="checkbox"/> SULFA
<input type="checkbox"/> CODEINE	<input type="checkbox"/> LIDOCAINE	<input type="checkbox"/> TETRACYCLINE
<input type="checkbox"/> DEMEROL	<input type="checkbox"/> MORPHINE	<input type="checkbox"/> X-RAY DYES
<input type="checkbox"/> ENVIRONMENTAL	please explain environmental/other	
<input type="checkbox"/> OTHER	_____	

Medical Information - Medical Conditions

- | | |
|--|---|
| <input type="checkbox"/> NO KNOWN CONDITIONS | <input type="checkbox"/> HEART VALVE PROSTHESIS |
| <input type="checkbox"/> ABNORMAL EKG | <input type="checkbox"/> HEMODIALYSIS |
| <input type="checkbox"/> ADRENAL INSUFFICIENCY | <input type="checkbox"/> HEPATITIS-TYPE 1 |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HYPOGLYCEMIA |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> LEUKEMIA |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> LYMPHOMAS |
| <input type="checkbox"/> CARDIAC DYSRHYTHMIA | <input type="checkbox"/> MEMORY IMPAIRED |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> MYASTHENIA GRAVIS |
| <input type="checkbox"/> CLOTTING DISORDER | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> CORONARY BYPASS GRAFT | <input type="checkbox"/> RENAL FAILURE |
| <input type="checkbox"/> DEMENTIA <input type="checkbox"/> ALZHEIMER'S | <input type="checkbox"/> SEIZURE DISORDER |
| <input type="checkbox"/> DIABETES/INSULIN DEPENDENT | <input type="checkbox"/> SICKLE CELL ANEMIA |
| <input type="checkbox"/> EYE SURGERY | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> HEARING IMPAIRED | <input type="checkbox"/> VISION IMPAIRED |
| <input type="checkbox"/> OTHER please explain _____ | |

Medical Information - Healthcare Contacts & Details

DOCTOR'S NAME	PHONE
PREFERRED HOSPITAL	BLOOD TYPE
HEALTH CARE AGENT	PHONE
RELIGIOUS & OTHER ADVISORS	

MY LIVING WILL/DPOAH can be found at: _____

medication *information*



updated

Current Medications

I DO NOT TAKE ANY prescribed or over-the-counter medications.

MEDICATION NAME	DOSEAGE	FREQUENCY

Relevant Medical History

SURGERIES, TESTS, ETC.

Medical Insurance

INSURANCE
COMPANY

POLICY
NUMBER

Other Helpful Information

NOTES