Use pencil for ease in making changes

Recent Surgery: _____ Date: _____

_____

_____

_____

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

If yes, 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
( ) Fire Ants
( ) 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 #: _____

KEEP INFORMATION UP TO DATE !!
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 please for ease in making changes)

_____

_____

_____

Medical Problems	Medications	Dosage	Frequency

Pharmacy (ies): _____ Phone: _____

_____

Date of Birth: _____ Soc. Sec. # _____

Blood Type: _____ Religion: _____

Health Care Proxy on file at: _____

Living Will on file at: _____

SEE BACK OF CARD FOR ADDITIONAL INFORMATION