Emergency Medical Information

Date Updated: _____

Name: _____

Address: _____

_____

_____

Sex: Male / Female Date of Birth: _____

Primary Care Doctor: _____

Doctor's City, State, & Phone #: _____

Preferred Pharmacy: _____

Pharmacy's City, Phone #: _____

Medical Insurance Co.: _____

Policy #: _____

Other Medical Insurance: _____

Policy #: _____

Do you have a living will? Yes or No

Do you have a health care power of attorney? Yes or No

Emergency Contacts

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

Permission to release my medical information to my emergency contact/s X _____

Medical Data

Recent Surgeries/Hospitalizations + Date:

_____

_____

_____

_____

_____

Medical Conditions (mark all that apply)

Heart Disease		**Lung Disease**		**Kidney Disease**	
	CHF/Heart Failure		COPD/Emphysema		Failure
	High Blood Pressure		Asthma		Insufficiency
	Low Blood Pressure		Fibrosis		Dialysis
	High Cholesterol		Pneumonia		Kidney Stones
	Irregular Heart Beat		Bronchitis		Infections
	Pacemaker		Shortness of Breath		
	Heart Attack		Coughing		
	Angina or Chest Pain		Lung Pain		
	Heart Surgery/Bypass/Stent				
Stomach Disease		**Neurological Disease**		**Malignancy/Cancer**	
	Bowel Obstruction		Stroke		Lung
	Bleeding		Bleeding in Brain		Liver
	Diverticulitis		Seizures		Breast
	Hiatal Hernia		Multiple Sclerosis		Stomach
	GERD/Reflux		Parkinson		Leukemia
	Diarrhea		Headaches		Colon
	Blood in Stools		Alzheimer's or Memory Loss		Skin
					Other:
Endocrine Disease		**Other**			
	Diabetes		Arthritis		Weight Loss
	Thyroid:		Back Problem		Vision
	_____ High		HIV		Other
	_____ Low		Sickle Cell		
			Weight Gain		

Allergies (mark all that apply)

	Aspirin		Hydrocodone		Lidocaine		Sulfa
	Barbiturates		Insect Stings		Morphine		Tetracycline
	Codeine		Horse Serum or Vaccines		Novocain		X-Ray Dye
	Demerol		Latex		Penicillin		Other: