



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:

MEDICATION:

Medication	Dosage	Frequency

RECENT SURGERIES

Date of Surgery | Type of Surgery | Notes

HEALTH CARE PROXY

Location of Proxy Documents: _____

Living Will on File At: _____

Religion: _____

EMERGENCY MEDICAL SERVICES (EMS) PREFERENCES

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

Location of DNR Document: _____

MEDICAL CONDITIONS

Check all that apply

No known medical conditions	Hemodialysis
Abnormal EKG	Hemolytic Anemia
Angina	High Blood Pressure (Hypertension)
Asthma	Hypoglycemia
Bleeding disorder	Laryngectomy
Cardiac Dysrhythmia	Leukemia
Cataracts	Lymphomas
Clotting Disorder	Memory Impaired
Coronary Bypass Graft	Myasthenia Gravis
Dementia/ Alzheimer's	Pacemaker
Diabetes/Insulin Dependent	Renal Failure
Eye Surgery	Seizure Disorder
Glaucoma	Sickle Cell Anemia
Hearing Impaired	Stroke
Heart Valve Prosthesis	Vision Impaired

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 INFORMATION

Insurance Provider: _____

Policy Number: _____

Group Number: _____

Other Medical Insurance Provider _____

Medicaid #: _____

Medicare #: _____

ADDITIONAL NOTES
