MEDICAL INFORMATION

DATE COMPLETED:

FIRST NAME	INITIAL	LAST NAME					
STREET	CITY	STATE	ZIP			PHONE	
DATE OF BIRTH	MALE/FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	BLOOD TYPE	RELIGION
LIST HEARING DIFFICULTIES						DENTURES UPPER LOWER	UNABLE TO SPEAK ☐
LIST VISION DIFFICULTIES						PRIMARY LANGUAGE (IF NOT ENGLISH)	

IDENTIFYING MARKS

CURRENT MEDICAL CONDITIONS

PAST MEDICAL CONDITIONS

CURRENT MEDICATIONS (DOSAGE & FREQUENCY)

ALLERGIES TO MEDICATIONS/HOW REACTIONS PRESENT

DOCTOR'S NAME & PHONE NUMBER

LAST HOSPITALIZATION

SPECIAL INSTRUCTIONS (ADVANCED HEALTH DIRECTIVE, ETC. AND WHERE TO LOCATE PAPERWORK)

HEALTH INSURANCE POLICY

EMERGENCY CONTACT - NAME, ADDRESS, PHONE NUMBER & RELATIONSHIP

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