

Name:			Medicare #:		
Address:		City:		State:	Zip Code:
Phone:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status	
Do you have a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is a copy of the Living Will enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a <b>Do Not Resuscitate</b> Order (DNR)? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, enclose a copy		
<b><i>If there is not DNR enclosed – EMS WILL RESUSCITATE YOU!</i></b>					
Insurance Company:	Policy #:	Secondary Ins. Co.:	Policy #:		

**In Case of Emergency, Please notify:**

Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:

**Medical Information**

Primary Physician:	Address:		Phone:
Secondary Physician:	Address:		Phone:
Take me to the Following Hospital	Height:	Weight:	Normal Blood Pressure: /
<b>CHECK ALL THAT APPLIES:</b> <input type="checkbox"/> Pacemaker <input type="checkbox"/> Use Oxygen <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Dentures <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____			
<b>Medical History:</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Past Stroke <input type="checkbox"/> Past Seizure <input type="checkbox"/> Heart Disease <input type="checkbox"/> COPD <input type="checkbox"/> Epilepsy <input type="checkbox"/> BP Issues <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer <input type="checkbox"/> Glaucoma <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Arthritis <input type="checkbox"/> TB <input type="checkbox"/> Asthma <input type="checkbox"/> Other _____ Currently Being Treated For: _____			
Medication Allergies:			
Food Allergies:			
What medical problems/physical disabilities do you have?			
Past Surgeries: (Type and Date)			
Type:	Date:	Type:	Date
Type:	Date:	Type:	Date
Where do you keep your medications?			

See Medication List on other side

