Medical Emergency Information

Name:			Date
Birthdate:	Sex	Height/Weight	Blood Type
Address			
City		State	Zip Code
Primary Insurance Co.		Occupation:	
Primary Insurance			

Past Medical History

Allergies	Cardiac	Surgery
O None XX O Unknown Medical Allergies: _____ _____ _____ _____ _____ _____ _____	O None XX O Unknown O Angina O Arrhythmia O Cardiomyopathy O CHF O Congenital O Implanted Defib O MI Other_____	O None XX O Unknown O Abdominal O Heart O Lung O Neurological Other_____ _____ _____ _____

Chronic Illnesses

O None XX O Asthma O Bleeding Disorder O Cancer O COPD O CVA / TIA O Diabetic	O Dialysis/Renal O Gastrointestinal O Headaches O Hepatitis O HIV + O Hypertension O Paralysis	O Psychological O Seizures O Substance Abuse O TB O Unknown Other_____ _____

Current Medications

O None O Unknown _____
_____

Emergency Contact Information

Primary Physician	Physician Phone Number
Primary Contact Name & Relationship	Primary Contact Phone Numbers
Secondary Contact Name & Relationship	Secondary Contact Phone Numbers

Client#

Additional Information / List Medication Names and Dosage