Keep one in your glove box in an envelope clearly marked In case of Emergency.

Use pencil for ease in making changes

Recent Surgery: **Date:**

Do you have an EMS-NO CPR Directive or a DNR form ?
YES ☐ **NO** ☐ **Where is it located ?**

MEDICAL CONDITIONS

Check all that exist

- ☐ No known medical conditions
- ☐ Abnormal EKG
- ☐ Adrenal Insufficiency
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cardiac Dysrhythmia
- ☐ Cataracts
- ☐ Clotting Disorder
- ☐ Coronary Bypass Graft
- ☐ Dementia ☐ Alzheimer's ☐
- ☐ Diabetes/Insulin Dependent
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Valve Prosthesis
- ☐ Other:
- ☐ Hemodialysis
- ☐ Hemolytic Anemia
- ☐ Hepatitis-Type [ ]
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Memory Impaired
- ☐ Myasthenia Gravis
- ☐ Pacemaker
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision Impaired

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Environmental:
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Rays Dyes
- ☐ No Known Allergies
- ☐ Other:

MEDICAL INSURANCE

Med Ins Co:

Policy #:

Other Med Ins Co:

Policy #:

Medicaid #: Medicare #:

KEEP INFORMATION UP TO DATE !!

***Review* At Least Every Six Months !**

MEDICAL DATA REVIEWED AS OF MO. YR.

Name: Sex: M F

Address:

Doctor: Phone #:

Preferred Hospital:

EMERGENCY CONTACTS

Name: Phone #:

Address:

Name: Phone #:

Address:

MEDICAL DATA

Use pencil for ease in making changes.

Special Conditions/Remarks:

Medication	Dosage	Frequency

Pharmacy: Phone:

Date of Birth:

Blood Type: Religion:

Health Care Proxy on file at:

Living Will on file at: