EMERGENCY MEDICAL INFORMATION

Name:	Date:
Address:	
City:	Zip Code:
Home Phone: ( )	Cell Phone: ( )
Date of Birth: / /	Age:
Social Security Number:	

Medical History

Please check any medical conditions that apply.

☐ Cardiac
☐ Diabetes
☐ Stroke
☐ Cancer
☐ Glaucoma
☐ Asthma
☐ Hypertension
☐ Renal Dialysis
☐ Congestive Heart Failure
☐ Chronic Obstructive Pulmonary Disease
☐ Angina
☐ GERD/Acid Reflux

Please list any recent surgeries or additional medical history below:

Family Physician/Specialist:

Preferred Hospital:

Medications: *Please list all medications below or include a printout from your pharmacist.*

Medication	**Dosage**	**Frequency**

Allergies: *Please list below any allergies to medications or food.*

Advanced Directives: Please attach any applicable paperwork (i.e., DNR) ☐ Yes ☐ No

Emergency Contact Information:

Name:	Name:
Relationship:	Relationship:
Phone:	Phone:
Address:	Address:
City/State/Zip:	City/State/Zip