EMERGENCY MEDICAL INFORMATION FORM

Name____ Phone: Home _________________ Cell _________________

Address____ City_________________ State_______ Zip___________

Gender_______ Date of Birth_____/______/_____ Age_____ Height_____ Weight_____ Social Security Number__________________

In an Emergency notify___________________________Relationship____________Phone: Home _______________ Cell ____________

MEDICAL INFORMATION

Medical Insurance___________________________ Policy #________________________ Phone: ______________________

Blood Type_____ Medicare: Yes No Medicare #_____________ Do you have a pacemaker? Yes No Date of last Tetnus shot____/____/____

Physician's name__________________________ Specialist?________________________ Phone: ______________________

Physician's name__________________________ Specialist?________________________ Phone: ______________________

Allergies________________________________ Explain____

Do you wear: Dentures Bridge(s) Contacts Glasses Hearing Aids Prosthetics

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MEDICAL HISTORY

HYPERTENSION HEART DISEASE SEIZURES ASTHMA DIABETES CANCER

G. I. PROBLEMS LUNG DISEASE HYPOGLYCEMIA OTHER___________________________________

Any recent surgery? Explain____

Foreign travel? When__________________________ Where____

MEDICINES CURRENTLY TAKING

	MEDICATION	FOR	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR
1.	______________	________________	______________	______________	___________________
2.	______________	________________	______________	______________	___________________
3.	______________	________________	______________	______________	___________________
4.	______________	________________	______________	______________	___________________
5.	______________	________________	______________	______________	___________________

Additional Comments:____ Date Completed or Revised_________________________

Attach a copy of insurance card. List any herbal remedies, and/or over the counter meds being taken____