Emergency Medical Information Form

Date Completed: ______________________

NAME:

______________________________ ________ ______________________________ ______________________

First | Middle Initial | Last | Date of Birth

MEDICAL CONDITIONS:

Diabetes
Heart Disease
Heart Failure
Stroke
Asthma

COPD
Arthritis
Cancer
High Blood Pressure
Alzheimer's Disease/ Dementia

Other (please specify)

ALLERGIES (Food, medication and/or environmental)

SURGERIES AND DATES:

______________________________ ______________ ______________________________ ______________

______________________________ ______________ ______________________________ ______________

______________________________ ______________ ______________________________ ______________

______________________________ ______________ ______________________________ ______________

PHYSICIANS:

First & Last Name: | **Specialty:** | **Address:** | **Phone:**

______________________________ ______________________ ______________________ ______________

______________________________ ______________________ ______________________ ______________

______________________________ ______________________ ______________________ ______________

______________________________ ______________________ ______________________ ______________

HOSPITAL PREFERENCE:

____

INSURANCE:

____

EMERGENCY CONTACTS:

Name:	Relationship:	Home Phone:	Work Phone:

MEDICATIONS:

Name:	Dosage/Strength:	Quantity:	Purpose/Special Instructions:

Do you have an advance directive? YES NO

Consider filing a scanned copy of your advance directives on the flash drive with your Emergency Medical Information.