

Recent Surgery: _____

Date: / /

Religion: _____

Living Will on file at: _____

Health Care Proxy on file at: _____

Do you have an EMS-NO CPR Directive or a DNR form? Yes No

If yes, where is it located? _____

MEDICAL CONDITIONS

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

ALLERGIES

- | | | |
|---|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Morphine | <input type="checkbox"/> X-Ray Dyes |
| <input type="checkbox"/> Horse Serum | <input type="checkbox"/> Novocaine | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Environmental: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

MEDICAL INSURANCE

Primary Medical Ins Co: _____
Policy or ID # _____ Group: _____

Secondary Medical Ins Co: _____
Policy or ID # _____ Group: _____

Additional Medical Ins Co: _____
Policy or ID # _____ Group: _____