MEDICAL AND PERSONAL INFORMATION

Keep a copy on your refrigerator at home and one in your car.

Today's date ____/____/____ *(Update information every four months.)*

Personal Information

Name ______________________ Date of birth ____________

Address ______________________

City ____________ State ____________ Zip ____________

Phone ____________ Preferred language ____________

Gender: ☐ Male ☐ Female Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary health insurance ____________ Policy No ____________

Secondary health insurance ____________ Policy No ____________

Do you have an Advance Directive? ☐ Yes ☐ No

If yes, who is the person you named to make decisions for you?

Name ______________________ Phone ( ) ____________

Where can we find a copy of your Advance Directive? ____________

Emergency Contacts

Name ____________ Relationship ____________ Phone ( ) ____________

Address ______________________

Name ____________ Relationship ____________ Phone ( ) ____________

Address ______________________

Name ____________ Relationship ____________ Phone ( ) ____________

Address ______________________

Clergy name ______________________ Phone ( ) ____________

Pet name/type ____________ Pet sitter ____________ Phone ( ) ____________

Medical Information

Primary care physician ______________________ Phone ( ) ____________

Specialist *(specify)* ______________________ Phone ( ) ____________

Specialist *(specify)* ______________________ Phone ( ) ____________

Location of hospital records ______________________ Phone ( ) ____________

Normal blood pressure ______/______ Height ____________ Weight ____________

Drug allergies ______________________

Food allergies ______________________

Medical problems/physical disabilities *(e.g. heart problems, diabetes, high blood pressure)*

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