Medication	Dose	Frequency

Dose	Frequency
_	
	Dose

My Personal History & **O**ther Documentation



Fill out and hang this brochure on your fridge for emergency responders.



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- 32 private treatment rooms
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Steward

Personal Information

Name:
Date of Birth:
Address:
City:
State:Zip Code:
Home Phone: ()
Cell Phone: ()
Sex: 🔲 Male 🛛 🖸 Female
Organ Donor: 🔲 Yes 🔲 No
Blood Type:

Emergency Contacts

Vame:Address: City:	
State:Zip Code:	
Home Phone: ()	
Cell Phone: ()	
Relationship:	
Name:Address:	_
City:	
State:Zip Code:	
Home Phone: () Cell Phone: () Relationship:	

Doctors

Primary Care Physician:	
Primary Care Phone: ()	
Other Physician:	
Phone: ()	
Pharmacy Name:	
Pharmacy Phone: ()	

Allergies:

None Known	🔲 Latex
Aspirin	🔲 Lidocaine
Barbiturates	🔲 Morphine
Codeine	🔲 Novacaine
Demerol	🔲 Penicillin
Environmental	🗖 Sulfa
Horse Serum	Tetracycline
Insect Stings	🔲 X-ray Dye/
	Shellfish
Food:	
Other:	

Primary Medical Insurance

Company:	
Policy Number:	
Medicare Number:	
Medicaid Number:	
-	

Other Medical Insurance

Name:	

Name: ______
Policy Number: ______

Other Information

Do you have an Advance Directive?

🔲 Yes 🗋 No

Where is it located?
Religion:
Living will on file at:
Health care proxy on file at:
hospital.

Medical History

No Known Medical Conditions
Abnormal EKG
Adrenal Insufficiency
Anemia
Angina
Asthma
Bleeding Disorder
Cancer
Cardiac Arrhythmia
Cataracts
Circulation Problems
Clotting Disorder
Coronary Bypass Grafts Dementia / Alzheimer's
Diabetes
Eye Surgery Glaucoma
Hearing Impaired
Heart Attack / MI
Heart Stents / Angioplasty
Heart Valve Prosthesis
Hemodialysis Hypertension
Hypoglycemia
Kidney Failure Leukemia / Lymphoma
Memory Impaired
Pacemaker / Defibrillator
Seizure Disorder
Stroke / TIA's
Thyroid Problems
Vision Impaired