Medication	Dose	Frequency

Medication	Dose	Frequency

Additional Information and Notes:

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Saint Anne's Hospital

A STEWARD FAMILY HOSPITAL

795 Middle Street
Fall River, MA 02721
508-674-5600
www.saintanneshospital.org

My Personal History & Other Documentation

Name: ______________________________

Saint Anne's Hospital

A STEWARD FAMILY HOSPITAL

World-class health care where you live.

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

Name: ______________________________
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
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Demerol
- ☐ Environmental
- ☐ Horse Serum
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novacaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-ray Dye/ Shellfish
- ☐ Food: ______________________________
- ☐ Other: ______________________________

Primary Medical Insurance

Company: ______________________________
Policy Number: ______________________________
Medicare Number: ______________________________
Medicaid Number: ______________________________

Other Medical Insurance

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.
Name: ______________________________

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