7/17/14

NAME: _____ **DATE OF BIRTH:** _____

FULL ADDRESS: _____

WHERE ARE YOUR MEDICATIONS STORED? _____

HOSPITAL PREFERENCE: _____

DRUG/FOOD ALLERGIES:

MEDICATION AND OVER THE COUNTER DRUGS YOU ARE CURRENTLY TAKING

EMERGENCY CONTACT(S)

NAME	RELATION	PHONE NUMBER

PHYSICIAN

NAME	PHONE NUMBER

HISTORY

HEART AILMENT/FAILURE		DIALYSIS		MEMORY LOSS	
PACEMAKER		HIGH BLOOD PRESSURE		DEAF	
DIABETES		LOW BLOOD PRESSURE		BLIND	
EPILEPSY		ASTHMA		CATARACTS	
EMPHYSEMA		STROKE		GLASS EYE	
KIDNEY PROBLEMS		SPEECH IMPEDIMENT		CONTACT LENSES	
DENTURES		SICKLE CELL TRAIT			

MAJOR OPERATIONS

OPERATION	DATE

MISCELLANEOUS INFORMATION