NAME: DATE:
DOB:

IDENTIFYING INFORMATION:

GENDER: BLOOD TYPE: PULSE:
HT: NORMAL BP:
WT: MARITAL STATUS:

PRIMARY INS: PHONE:
MEMBER #: FAX:

SECONDARY INS: PHONE:
MEMBER #: FAX:

PHARMACY:
1 MO: PHONE: FAX:
3 MO: PHONE: FAX:

ADVANCED HEALTH CARE DIRECTIVE? Y N

Primary Agent:
NAME:
RELATIONSHIP:
PHONE:

Secondary Agent:
NAME:
RELATIONSHIP:
PHONE:

DO NOT RESUSITATE ORDER? Y N

HIPPA PRIVACY WAIVER? Y N

NOTIFY IN CASE OF EMERGENCY

NAME	RELATIONSHIP		PHONE	LOCATION

OTHERS LIVING IN THE HOME

NAME	RELATIONSHIP

NAME: **DATE:**
DOB:

PROTOCOLS FOR: **NAUSEA:** **PAIN:**

MEDICATIONS										
MEDICATION		DOSE TIMES (military)								
NAME	DOSE									
PD MEDS										
GI MEDS										
OTHER MEDS										

SUPPLEMENTS				
BRAND	SUPPLEMENT	DOSE	X/DAY	NOTES

NAME: **DATE:**
DOB:

DATE:		DIAGNOSIS:

DATE:		SURGERIES/PROCEDURES:

ALLERGEN:		REACTION:

VACCINES:

DENTURES Y/N
GLASSES Y/N
CONTACTS Y/N
USES OXYGEN Y/N

HEARING AIDS Y/N
CATHETER Y/N
INTERNAL Y/N
EXTERNAL Y/N

NAME: **DATE:**
DOB:

MEDICAL TEAM				
Specialty	**Last Appt**	**Name**	**Phone**	**Nxt Appt**

HOSPITALIZATIONS

A. Hospital: **Reason for admission:**
Address: **Surgery/Procedure:**
Date/s:
Phone:

B. Hospital: **Reason for admission:**
Address: **Surgery/Procedure:**
Date/s:
Phone:

C. Hospital: **Reason for admission:**
Address: **Surgery/Procedure:**
Date/s:
Phone:

D. Hospital: **Reason for admission:**
Address: **Surgery/Procedure:**
Date/s:
Phone: