



KEEP INFORMATION UP TO DATE

LAST UPDATED / /

NAME:

DATE OF BIRTH: / / SEX:

ADDRESS:

PHONE: LANGUAGE:

ADVANCE CARE PLANNING / DNR DOCUMENTS LOCATION:

No advance directive / no DNR

EMERGENCY CONTACTS

PRIMARY CONTACT:

PHONE #: RELATIONSHIP:

Is this your healthcare proxy decision maker? Yes No

SECONDARY CONTACT:

PHONE #: RELATIONSHIP:

MEDICAL DATA

Do you use any assistive devices?

- Eyeglasses / Contacts Walker Service Animal
 Hearing Aids Cane Prosthetic
 Communication Device / Tablet Wheelchair Other (list below):

DO YOU TAKE BLOOD THINNING MEDICATION? Yes No

MEDICATIONS

DOSE

FREQUENCY

MEDICAL CONDITIONS

NO KNOWN MEDICAL CONDITIONS

CARDIAC / VASCULAR:

- ABNORMAL HEART RHYTHM
- ANEMIA
- ANGINA (CHEST PAIN)
- AORTIC ANEURYSM
- BLEEDING / CLOTTING DISORDER
- BLOOD TRANSFUSION [# ____]
- CONGESTIVE / CHRONIC HEART FAILURE
- CORONARY ARTERY DISEASE
- DVT (BLOOD CLOT)
- HEART MURMUR
- HYPERTENSION
- PREVIOUS HEART ATTACK / MI
- SICKLE CELL ANEMIA

SYSTEMIC / OTHER:

- CANCER, TYPE _____
- HEPATITIS, TYPE _____
- HIV / AIDS
- LUPUS
- ALCOHOL USE DISORDER
- OPIOID USE DISORDER
- DEPRESSION
- ANXIETY

OTHER (list):

PULMONARY / RESPIRATORY:

- ASTHMA
- COPD
- TOBACCO USE
[Packs per day: _____]
- TUBERCULOSIS

NEUROLOGIC / SENSORY:

- CONCUSSION / TBI
- DEMENTIA / ALZHEIMER'S
- DEVELOPMENTAL DELAY
- GLAUCOMA
- HEARING IMPAIRMENT
- NEUROLOGIC DEFICIT / WEAKNESS
- SEIZURE DISORDER
- STROKE / TIA (mini stroke)
- VISION IMPAIRMENT

ENDOCRINE / METABOLIC / RENAL:

- ADRENAL INSUFFICIENCY
- DIALYSIS
- KIDNEY DISEASE
- TYPE 1 DIABETES
- TYPE 2 DIABETES

SURGICAL HISTORY

NO SURGICAL HISTORY

- CARDIAC VALVE REPLACEMENT
- CARDIAC STENT REPLACEMENT
- CORONARY ARTERY BYPASS GRAFT (CABG)
- GALLBLADDER REMOVAL
- OTHER (list):
- GASTRIC SLEEVE / BYPASS
- HYSTERECTOMY
- JOINT REPLACEMENT
- PACEMAKER
[Brand: _____]

ALLERGIES

[Indicate allergy by writing the letter that corresponds with reaction]

A = anaphylaxis (breathing issue), N = nausea, R = rash, O = other/unknown

NO KNOWN ALLERGIES

- ___ ASPIRIN
- ___ CONTRAST DYE (IV or oral)
- ___ LIDOCAINE / LOCAL ANESTHETICS
- ___ OPIOIDS (morphine, codeine, etc.)
- ___ PENICILLIN
- ___ SULFA DRUGS
- ___ TETRACYCLINE
- OTHER (list with reaction):
- ___ INSECT STINGS
- ___ LATEX
- ___ MEDICAL TAPE
- ___ PEANUTS / TREE NUTS
- ___ SHELLFISH
- ___ WHEAT / GLUTEN

MEDICAL INSURANCE

Primary Care Pr.:

Preferred Hospital:

Ins. co.:

Policy #:

Medicaid #:

Medicare #:

Religion / requests / other remarks: