Medical Information

Information to Share in Case of Emergency

Your Name _____ Date of Birth _____

Medical Insurance (list all) _____

Your Address _____ Your Phone # _____

Emergency Contact Name #1 _____ Phone # _____

Emergency Contact Name #2 _____ Phone # _____

Primary Care Provider Name _____ Phone # _____

Other Doctor Names (ex: heart doctor) _____

Preferred Hospital _____ Advanced Directive (circle): YES NO

Allergies (medications and food) _____

_____

_____

Medical Conditions

_____

_____

_____

_____

_____

_____

Current Medications (name and dose)

_____

_____

_____

_____

_____

_____

Surgeries / Year Performed

_____

_____

_____

_____

_____

_____

I take a blood thinner (circle): YES NO

Current mobility (check all that apply):

- ☐ Walk Independently
- ☐ Unable to Walk
- ☐ Use Walker
- ☐ Use Cane
- ☐ Wheelchair (I can transfer on my own)
- ☐ Wheelchair (I need help transferring)

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