Lifesaving Information for Emergencies Date:

PERSONAL INFORMATION:

		Phones: (*mark "best" #*)	
Name:		**Home:**	
Address (line 1):		**Work:**	
Address (line 2):		**Mobile:**	
City, state, zip:		**Other:**	

Date of Birth:	**Height:**	**Weight:**	**Gender:** M F

Hair Color	Eye Color	Dentures	Blood Type	Religion	❑ Non-English Speaker
		❑Upper ❑ Lower			Primary Language

Primary Physician:		**Phone #:**	
Secondary Physician:		**Phone #:**	

MEDICAL HISTORY:

❑ HIV / AIDS	❑ Hepatitis	❑ Hearing Problems	❑ Breathing Problems	❑ High Blood Pressure
❑ Epilepsy	❑ Seizures	❑ Eye Problems	❑ Emphysema	❑ Low Blood Pressure
❑ Stroke	❑ Cancer	❑ Eye Glasses	❑ Hypoglycemia	❑ Heart Condition
❑ Anemia	❑ Diabetes	❑ Hemophilia	❑ Defibrillator	❑ Pacemaker
❑ TB	❑ Glaucoma	❑ Ulcers / GERD	❑ Dementia / Alzheimer's	

Other:

ALLERGIES:

❑ **NO known Allergies**	❑ Aspirin	❑ Codeine	❑ Demerol	❑ Morphine
❑ Insect Stings	❑ Latex	❑ Sulfa	❑ Penicillin	❑ Tetanus

Other:

CURRENT MEDICATIONS: *[list everything you take on a regular basis: prescriptions, over the counter drugs, vitamins, herbal supplements, eye drops, etc.]*

Name of Medication	**Dosage** (e.g. 20 mg)	Time(s)

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OTHER TREATMENT REGIMENS:

Currently on Chemo Therapy?	Y/N	MD to contact?	
Currently on Blood Thinners?	Y/N	If "Yes" – How Much?	
Currently on Insulin?	Y/N	If "Yes" – How Often?	
Currently on Oxygen?	Y/N	If "Yes" – How Much?	

Other Health Insurance **Medicare #:**

Name:		Policy #:		Phone #:	
Name:		Policy #:		Phone #:	

IN CASE OF EMERGENCY PRIMARY CONTACT:

Phones: (*mark "best" #*)

Name:		Home:	
RELATIONSHIP:		Work:	
Address:		Mobile:	
City, state, zip:		Other:	

IN CASE OF EMERGENCY SECONDARY CONTACT:

Phones: (*mark "best" #*)

Name:		Home:	
RELATIONSHIP:		Work:	
Address:		Mobile:	
City, state, zip:		Other:	

ADVANCE DIRECTIVES: do you have:

Do Not Resuscitate Order:	Y/N	Location:	
Living Will:	Y/N	Location:	
Durable Power of Attorney for Health:	Y/N	Location:	

Other helpful information: *Other special needs, surgeries in the recent past, etc.*