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

SEE BACK OF CARD

® FILE OF LIFE

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

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

SYSTEMIC / OTHER:

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

ENDOCRINE / METABOLIC / RENAL:

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

☐ **OTHER (list):**

SURGICAL HISTORY

☐ NO SURGICAL HISTORY

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

☐ OTHER (list):

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
- ___ INSECT STINGS
- ___ LATEX
- ___ MEDICAL TAPE
- ___ PEANUTS / TREE NUTS
- ___ SHELLFISH
- ___ WHEAT / GLUTEN

☐ OTHER (list with reaction):

MEDICAL INSURANCE

Primary Care Pr.: Preferred Hospital:

Ins. co.: Policy #:

Medicaid #: Medicare #:

Religion / requests / other remarks: