Emergency Medical Form

Name _____ Preferred name:_____

Address _____City _____ State_____
Zip Code_____ Phone_____ Alternative phone_____
Email _____ Sex _____ Race_____ Height_____ Weight _____

Native Language_____ Date of Birth_____

Place of Birth_____SSN:_____ (keep this information secure)
Blood Type _____ Prior transfusion reaction (describe):

_____

Please check all that apply:

Contact lenses _____ Dentures _____ Diabetic_____ Epileptic_____ Glasses ____ Hearing Aid_____
Metal in body_____ Pacemaker_____ Walker or Cane_____

Additional information:

_____

Allergies to medications? _____ Please list_____

All other allergies: _____
Medical Conditions (check for current conditions only)

	AIDS/HIV		Dialysis		Respiratory Problems
	Anemia		Dementia		Sickle Cell
	Arthritis		Epilepsy		Stroke
	Asthma		Glaucoma		Tuberculosis
	Cancer		Heart Condition		ALS
	Diabetes		High Blood Pressure		Long Covid

List all other medical conditions:

_____
_____
List Dietary Restrictions: _____

List all surgeries and hospitalizations:

Year	Surgery Performed	Reason for Hospitalization	Location

Insurance:

Medicare Beneficiary? Yes ___ No ___

Medicare Part D? Yes ___ No ___ Medicare # _____

Supplementary/Insurance Company _____ Phone _____
Group #_____ Policy #_____ Attach Copy of Cards

Preferred Hospital: _____

Primary physician and/or medical treatment facility:

Physician Name _____ Phone _____
Additional physicians/specialists:

Physician Name _____ Phone_____
Specialty:_____

Physician Name _____ Phone _____

Specialty: _____

Physician Name _____ Phone _____

Specialty: _____

Case Manager or Social Worker Information: Name _____ Agency
_____ Agency Phone # _____

Next of kin or person to be notified in an emergency:

Name _____ Relationship _____

Phone _____ Email _____

Name _____ Relationship _____

Phone _____ Email _____

Name _____ Relationship _____

Phone _____ Email _____

Legal documents: Attach a copy and instructions on where to access originals.

Is there a Power of Attorney? Yes ___ No ___

Is there an Alabama Advanced Directive (Living Will) Yes ___ No ___

Is there a Do Not Resuscitate order? Yes ___ No ___

Health Care Proxy/Power of Attorney Contact Info:

Name _____ Relationship _____

Phone _____ Email

_____

Pharmacy: Name and location_____Phone _____

Medication List: Include over-the-counter, vitamins and prescription medications.

Rx Name	Dose	Frequency	Reason for taking	Prescribed by MD/DO/NP/PA

Any other information important for proper treatment:

_____

_____

_____

_____

_____