

General Information

Name: _____ Date: _____

Address: _____ Phone: _____

City, State: _____ Zip Code: _____

Date of Birth: __ __ / __ __ / __ __ Gender: Male __ Female __

Height: __ __ Weight: __ __ Marital Status: Single __ Married __ Widowed __ Divorced __

Health Insurance Information

Social Security No. (last 4 digits): _____ Medicare Number: _____

Primary Insurance Company: _____ Policy Number: _____

Secondary Insurance Company: _____ Policy Number: _____

Have you filled out an Advance Directive for Health Care Form? Yes __ No __

If yes, name of health care agent: _____ Phone: _____

Have you requested a Do Not Resuscitate order? Yes __ No __ If Yes, enclose/attach.

Notify in Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Others Living in the Home

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Pet Name/Type _____ Pet Sitter Name: _____ Phone: _____

Medical Information

Primary Physician: _____ Phone: _____

Secondary Physician: _____ Phone: _____

Specialty Physician: _____ Phone: _____

Location of Hospital Records: _____

Normal Blood Pressure: _____

Drug Allergies (specify): _____

Food Allergies (specify): _____

What medical problems/physical disabilities do you have? _____

List past surgeries (type and date): _____

Do you:

wear dentures? Yes ___ No ___

wear glasses? Yes ___ No ___

wear contacts? Yes ___ No ___

wear a hearing aid? Yes ___ No ___

use oxygen? Yes ___ No ___

Where do you keep your medications? _____

Current Medications (list prescription, over the counter drugs, vitamins, herbal supplements, eye drops, etc.)

Name: _____ Dosage: _____ Times: _____

Name: _____ Dosage: _____ Times: _____

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Name: _____ Dosage: _____ Times: _____

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