

Medical Info

Name: _____ Preferred Name: _____
 Address: _____
 Phone: _____ Date of Birth: _____
 Primary Language: _____ Secondary Language: _____
 Gender: _____
 Primary Insurance: _____ Policy: _____
 Secondary Insurance: _____ Policy: _____
 Do you have a living will? Y N Health Care Proxy: Y N
 Health Care Proxy: _____ Phone: _____

Emergency Contacts

Name	Phone	Relationship

Physicians

Type	Name	Phone	Notes
Primary			
Secondary			

Preferred Hospital: _____ Phone: _____

List of Medical Conditions:

Baselines:

Weight: _____
 Blood Pressure: _____
 Blood Sugar: _____
 Blood Type: _____

Allergies:

Type	Reaction