

# EMERGENCY MEDICAL INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ MedGuard member? Y N

Insurance Carrier: \_\_\_\_\_ ID #: \_\_\_\_\_

Other insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Physician: \_\_\_\_\_ Hospital Preference: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Ph# \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you have a DNR or a MOLST form? Y N (if yes please attach a copy to this form)

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## MEDICAL HISTORY

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|---|---|---|
| 1) Are you Diabetic?                              | Y | N |
| 2) Do you have a cardiac problem?                 | Y | N |
| 3) Do you have a seizure disorder?                | Y | N |
| 4) Do you have COPD or Asthma?                    | Y | N |
| 5) DO you have High Blood Pressure?               | Y | N |
| 6) Have you ever had a Stroke?                    | Y | N |
| 7) Do you have any allergies? (please list below) | Y | N |

8) Please describe all other medical problems. (Use back of form if more space is needed)

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9) Please list all medications you are currently taking. (Prescription, non-prescription, and herbal)

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Date you filled out this form: \_\_\_\_\_

