Medical Information Form

Name _____ **Address** _____

City _____ **State**____ **Zip Code**_____ **Home phone**_____

Work phone_____ **Cell phone** _____ **Email** _____

Date of Birth_____ **SSN:**_____ *(keep this information secure)* **Blood Type** _____

Prior transfusion reaction (describe)_____

Please check all that apply:

Contact lenses____ Dentures____ Diabetic____ Epileptic____ Metal in body____

Additional information: _____

Allergies to medications?____ Please list _____

List all medical conditions:_____

_____

List Dietary Restrictions:_____

List all surgeries and hospitalizations:

Year	Surgery Performed/Reason for Hospitalization	Location

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 Oklahoma 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 phone _____

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

Rx Name	Dose	When to take	Reason for taking	Prescribing M.D.