Please review at least every six months. Medical data reviewed as of________________________

Do you have a DNR Form? ( ) YES ( ) NO If YES, where is it located? ____________________

PLEASE PRINT

NAME ______________________ Sex M F

Address ________________________________

Phone # ( )

Date of Birth	SSN#
Blood Type	Religion
Doctor	Phone #
Doctor	Phone #
Doctor	Phone #

ALLERGIES

( ) NO known allergies

( ) Latex

( ) Sulfa ( ) Penicillin

( ) Aspirin

( ) Insect Stings

( ) Food ______________________

( ) Other ______________________

MEDICAL HISTORY

(Please check all that exist)

( ) NO known medical conditions

( ) Heart Condition

- ( ) Abnormal EKG
- ( ) Pace Maker
- ( ) Hypertension
- ( ) Angina
- ( ) Cardiac Dysrhythmia

( ) Asthma ( ) Emphysema

( ) Cancer Type________________

( ) Diabetes Insulin Dependent ( ) YES ( ) NO

- ( ) Hypoglycemia ( ) Hyperglycemia

( ) Previous Stroke/TIA

( ) Seizure Disorder ( ) Epilepsy

( ) Dementia ( ) Alzheimers

( ) Vision Impaired ( ) Hearing Impaired

Hospital ( ) Marion General ( ) Delaware Grady ( ) Morrow County

MEDICAL CONDITION	MEDICATION	DOSAGE	FREQUENCY

Where I keep my medications: ______________________________________