



Basic Health Information

Name _____ Date of Birth _____

DRUG ALLERGIES/REACTIONS _____

MEDICAL CONDITIONS _____

ALL MEDICATIONS AND SUPPLEMENTS TAKEN DAILY OR OCCASIONALLY
(NAME, DOSE, DIRECTIONS)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DATE OF LAST VACCINATIONS

Tetanus _____ Pneumonia _____ Flu _____

Other _____

FAMILY DOCTOR/PRIMARY CARE PRACTITIONER

Name _____ Telephone _____

Address _____ E-mail _____

EMERGENCY CONTACT

Name _____ Telephone _____

Address _____ E-mail _____

LIVING WILL Yes No

Are you an Organ Donor? Yes No

DURABLE POWER OF ATTORNEY

Name _____ Telephone _____

Address _____