Jones
Memorial
Hospital
www.jmhny.org

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_____