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.