PERSONAL MEDICAL FORM

Name: Home Phone: ( )

Work Phone: ( ) Social Security Number:

Community: DOB

Health Insurance (Health Plan/Medicare):

Insurance/Medicare Number:

Location of Insurance Card/s:

Primary Care Physician: Phone: :( )

Specialist/Specialty: Phone: :( )

 Phone: :( )

 Phone: :( )

Health Care Proxy/Agent Name:

Living- Will/Durable Power of Attorney (Location):

Diagnosed Chronic Conditions: (arthritis, asthma, diabetes, high blood pressure etc.)

Do you have any physical handicaps? Yes No . If yes, please describe:

History of Major Illness/Injuries: (fractures, accidents, minor infections, include dates)

Surgical Procedures/ hospitalizations: Dates:

Medications:

# Drug Dose Purpose Instructions Date Prescribed

Allergies to Drugs, Food, Insects:

Other Pertinent Information: e.g. pacemaker, hearing- aid, vision problem, using, assistive device:

Pertinent Family History: \_\_\_\_\_

 \_\_\_\_\_

This information may be used in the event that I experience a medical emergency and am unable to provide pertinent, necessary information to medical personnel.

Signature: Date:

**Please send a copy of this form to the Provincial Offices/ Director of Health Services and to your Superior. Keep one on file in the local community and give one to your health proxy/agent as well. This form should be updated when there is a significant change. It is suggested that you keep a copy on the back of a door or in the medicine cabinet for easy access in case of emergency**