

HEALTH INFORMATION

N A M E (First, Last)	DATE OF BIRTH	GENDER	INFO UPDATED ON (date)	FIRST LANGUAGE

HOME ADDRESS	PHONE NUMBER	HEIGHT / WEIGHT

HOSPITAL OF CHOICE	SOCIAL SECURITY #

ALLERGIES <input checked="" type="checkbox"/>	No Known Drug Allergies	OVER THE COUNTER & PRESCRIBED MEDICATION LIST	MEDICATION	DOSE	TIME	ROUTE	SUPPLIES
	Penicillin						
	Contrast Dye						
	Sulfa Drugs						

MEDICAL AND SURGICAL HISTORY <input checked="" type="checkbox"/>	High Blood Pressure	OVER THE COUNTER & PRESCRIBED MEDICATION LIST					
	Coronary Artery Disease						
	Diabetes 1 or 2						
	COPD						
	Chronic Heart Failure						
	Asthma						
	Cancer						
	Seizures						
	Anxiety / Depression						
	Stroke / TIA						

MEDICAL AND SURGICAL HISTORY <input checked="" type="checkbox"/>	Chronic Kidney Disease	ASSISTIVE DEVICES	Cane	Oxygen		Feedings	
			Walker	Liters		Model	
			Wheelchair	Frequency		Brand	
			Hearing Aides	Supplier		Mode	
			Utensils	BIPAP		Frequency	
			Glasses	Model		Amount	
				Settings		Ventilator	
				CPAP		Model	
				Brand		Settings	
				Settings		Frequency	

Implanted Medical Devices
Joint
Valve
Pacemaker / ICD
Pain Pump
Insulin Pump

HEALTH INFORMATION

IMPORTANT NUMBERS

RESOURCE / NAME	PHONE NUMBER
EMERGENCY	911
Marion County Police Non-Emergency	311 or 3 1 7 - 3 2 7 - 3 8 1 1
Poison Control	1 - 8 0 0 - 2 2 2 - 1 2 2 2
Be Well Indiana	211
Suicide and Crisis Hotline Call or Text	988
Veterans Crisis Line	988 & Press 1 or Text 838255
Safe Call Now	2 6 0 - 4 5 9 - 3 0 2 0
Medical Power of Attorney	
Emergency Contact #1:	
Emergency Contact #2:	
Primary Care Physician or Nurse Practitioner:	
Specialist:	
Specialist:	
Specialist:	
Specialist:	
Eye Doctor:	
Dentist:	
Insurance Agent:	
Policy Number:	

COPY OF INSURANCE CARD

COPY OF IDENTIFICATION

COPY OF MEDICAL DEVICE IMPLANT
CARD

COPY OF GLASSES PRESCRIPTION