



For an Emergency, Call 911

For Non-Emergencies,
Call (703) 792-6500

KEEP INFORMATION UP TO DATE

Name: _____ Sex: _____
 M F

Address: _____

Date of Birth: / /

EMERGENCY CONTACTS

Name: _____ Home Phone #: _____

Address: _____

Relation: _____ Work Phone #: _____

Name: _____ Home Phone #: _____

Address: _____

Relation: _____ Work Phone #: _____

MEDICAL DATA

Last Updated: Mo. Yr. Blood Type:

Doctor: _____ Phone #: _____

Preferred Hospital: _____

Use pencil for ease in making changes.

Special Conditions/Remarks:

Medication	Dosage	Frequency

Use pencil for ease in making changes

Medication	Dosage	Frequency

Recent Surgery: _____ **Date:** _____

Religion: _____

Living Will on file at: _____

Health Care Proxy on file at: _____

Do you have an EMS-NO CPR Directive or a DNR form?

YES **NO** **Where is it located?**

MEDICAL CONDITIONS

Check all that exist

- | | |
|---|---|
| <input type="checkbox"/> No known medical conditions | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Hemolytic Anemia |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hepatitis-Type []] |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lymphomas |
| <input type="checkbox"/> Cardiac Dysrhythmia | <input type="checkbox"/> Memory Impaired |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Heart Valve Prosthesis | |
| <input type="checkbox"/> Other: _____ | |

ALLERGIES

- | | | |
|---|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Morphine | <input type="checkbox"/> X-Ray Dyes |
| <input type="checkbox"/> Horse Serum | <input type="checkbox"/> Novocaine | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Environmental: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

MEDICAL INSURANCE

Med Ins Co: _____

Policy #: _____

Other Med Ins Co: _____

Policy #: _____

Medicaid #: _____ Medicare #: _____