



Serving Calumet, Outagamie and Waupaca Counties
 Calumet County 920-849-1451
 Waupaca County 715-258-6400
 Outagamie County 920-832-5178
 1-866-739-2372 (TOLL FREE)

KEEP INFORMATION UP TO DATE
Review At Least Every Six Months

Last updated: Mo: _____ Yr: _____
 Name: _____ Sex: M F
 Address: _____
 City: _____ State: _____
 Doctor: _____ Phone #: _____
 Doctor: _____ Phone #: _____

EMERGENCY CONTACTS

Name: _____ Phone: _____
 Address: _____
 Name: _____ Phone: _____
 Address: _____

MEDICAL DATA

Use pencil for ease in making changes

Special Conditions/Remarks: _____

Medication	Dosage	Frequency

Preferred Hospital: _____
 Pharmacy: _____ Phone: _____
 Date of Birth: ____ / ____ / ____ Blood Type: _____
 Religion: _____
 Health Care Proxy on file at: _____
 Living Will on File at: _____

Recent Surgery: _____ Date: _____

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 | <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"/> Laryngectomy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cardiac Dysrhythmia | <input type="checkbox"/> Lymphomas |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Memory Impaired |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Valve Prosthesis | <input type="checkbox"/> Vision Impaired |
| <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-Rays Dyes |
| <input type="checkbox"/> Horse Serum | <input type="checkbox"/> Novocaine | <input type="checkbox"/> No Known |
| <input type="checkbox"/> Environmental: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

MEDICAL INSURANCE

Med Ins. Co: _____
 Policy #: _____
 Other Med Ins. Co: _____
 Policy #: _____
 Medicaid #: _____
 Medicare#: _____