EMERGENCY HEALTH FORM

Name: _____ **Date of Birth:** _____

Health History:

- ☐ **Heart Disease**
- ☐ **Stroke/TIA**
- ☐ **Diabetes**
- ☐ **Pace Maker or Defibrillator**
- ☐ **Cancer**
- ☐ **Hypoglycemia (Low blood sugar)**

List all other Medical Conditions: _____

Current Medications

NAME	DOSAGE	FREQUENCY

Allergies: _____

Primary Doctor's Name & Number: _____

Specialist's Names and Numbers: _____

Emergency Contact Name and Number: _____

Hospital Preference: _____

Do you have an Advanced Directive? Yes_____ NO_____

All Information on this form will be kept confidential and used only for emergency situations

This form will only be given to Emergency Medical Professionals.

Date Form Completed: _____