

Name: _____
Address: _____
Phone Number: _____
Date of Birth: _____

Update Every 6 Months

Last Updated on: _____

MEDICATION

Medications	Dose	Reason

EMERGENCY CONTACT

Name: _____ Name: _____
Phone #: _____ Phone #: _____
Relation: _____ Relation: _____

INSURANCE INFORMATION

Primary Insurance Info: _____ Primary Insurance Info: _____
Policy #: _____ Policy #: _____
Group #: _____ Group #: _____

MEDICAL DATA

Primary Doctor: _____ Primary Doctor: _____
Phone #: _____ Phone #: _____
Specialist: _____ Specialist: _____
Phone #: _____ Phone #: _____

CODE STATUS

Do you have a DNR (Do Not Resuscitate) Form? If yes, where is it?

Do you have a DNI (Do Not Intubate) Form? If yes, where is it?

Do you have a Living Will? If yes, where is it?

Have you selected a Healthcare Power of Attorney? Yes or No.

Name: _____ Phone #: _____

Courtesy of Nancy Ruffner, Patient Advocate - Consultant - Coach
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MEDICAL HISTORY

Circle All That Apply

No Medical Conditions	Heart Attack
Abnormal EKG	Hemodialysis
Adrenal Insufficiency	Hepatitis, Type:
Angina	High Blood Pressure
Asthma	Hypoglycemia
Bleeding Disorder	Pacemaker
Irregular Heartbeat	Renal Failure/Insufficiency
Cataracts	Seizures
Congestive Heart Failure	Sickle Cell Anemia
COPD/Emphysema	Stents
Heart Surgery	Stroke/TIA
Dementia/Alzheimer	Tuberculosis
Diabetes/Insulin Dependent	Vision/Hearing Impaired
Glaucoma	

Please List Any Other Medical Conditions:

ALLERGIES

Circle All That Apply

None	Lidocaine	X-Ray Dyes
Aspirin	Morphine	Medical Tape
Codeine	Novocaine	Valium
Demerol	Penicillin	NSAIDs
Bee Strings	Sulfa	Peanuts
Latex	Tetracycline	Seafood

Please List Any Other Medical Conditions:

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