



Personal Information

Date form Completed _____

Name:	Date of Birth:	Age:
Address:	Gender: Male Female	
City & Zip:	SSN#: (Optional)	
Phone:	Weight:	
Emergency Contact Name	Emergency Contact Phone:	
Physician Name	Physician Phone:	

Medical Information

Do you have an active and signed Do Not Resuscitate (DNR) (***if yes, please attach!***) Yes No

Do you have an Advance Health Care Directive? Yes No

Do you have some one who legally makes your medical decisions? Yes No

If yes, whom? _____ Relationship _____

Phone number for person stated on line above _____

Blood Type: _____ Religious Preference _____

Are you an organ donor? Yes No

Medical Conditions: Check all that apply ✓

AIDS / HIV	Epilepsy
Anxiety	Heart Attack: Year Occurred()
Asthma	Hepatitis (A) (B) (C) (D) (E) (F) (G)
Cancer	High Blood Pressure
CHF	Irregular Heart Beat
COPD	Pacemaker
Diabetes	Stroke
Emphysema	Thyroid

Other Major Medical conditions not listed

