VITAL MEDICAL INFORMATION FORM

Keep information up to date. Use pencil for ease when updating. Email contact.us@pchpca.org for additional forms.

MEDICAL INFORMATION REVIEWED: MONTH _____ YEAR _____

NAME: _____

ADDRESS: _____

GENDER: M / F **DATE OF BIRTH:** _____ **BLOOD TYPE:** _____

VETERAN: YES / NO **BRANCH OF SERVICE:** ARMY / NAVY / AIR FORCE / MARINES / COAST GUARD

RELIGION: _____

PRIMARY CARE PROVIDER: _____ **PRIMARY CARE PROVIDER PHONE:** _____

PRIMARY CARE PROVIDER CITY/STATE: _____

PREFERRED HOSPITAL: _____

PHARMACY: _____ **PHARMACY PHONE:** _____

EMERGENCY CONTACTS

HEALTHCARE REPRESENTATIVE NAME: _____ **PHONE:** _____

ADDRESS: _____

EMERGENCY NAME: _____ **RELATION:** _____

ADDRESS: _____ **PHONE:** _____

ALT. EMERGENCY NAME: _____ **RELATION:** _____

ADDRESS: _____ **PHONE:** _____

I HAVE THE FOLLOWING ADVANCE DIRECTIVES (check and circle all that apply)

☐ **HEALTHCARE REPRESENTATIVE:** LOCATED IN THIS FILE / LOCATED AT : _____

☐ **LIVING WILL:** LOCATED IN THIS FILE / LOCATED AT: _____

☐ **OUT OF HOSPITAL DO NOT RESUSCITATE ORDER:** LOCATED IN THIS FILE / LOCATED AT: _____

☐ **PHYSICIANS ORDER FOR SCOPE OF TREATMENTS (POST):** LOCATED IN THIS FILE / LOCATED AT: _____

☐ **ORGAN DONOR:** LOCATED IN THIS FILE / ON MY DRIVERS LICENSE / LOCATED AT: _____

VACCINATION HISTORY (check and include most recent date of all that apply)

☐ **INFLUENZA** _____ ☐ **PNEUMONIA (Pneumonalcoccal 23)** _____ ☐ **PNEUMONIA (Prevnar 13)** _____

☐ **COVID** _____ ☐ **SHINGLES** _____ ☐ **TETANUS** _____ **OTHER** _____

CONDITIONS AND INFORMATION NOT IDENTIFIED ON OTHER SIDE

_____

_____

_____

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

HISTORY OF SURGERIES

SURGERY / SURGEON'S NAME	DATE/YEAR	SURGERY / SURGEON'S NAME	DATE/YEAR

MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

Include additional information on the bottom of the first page.

- ☐ Addiction / Abuse / Alcoholism
- ☐ Adrenal insufficiency
- ☐ Anemia _____
- ☐ Aneurism _____
- ☐ Artificial limb _____
- ☐ Artificial joint _____
- ☐ Asthma _____
- ☐ Autoimmune disease _____
- ☐ Bleeding / clotting disorder
- ☐ Blood Pressure: High/Low
- ☐ Cancer _____
- ☐ Cholesterol—high
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Dementia / Alzheimer's
- ☐ Diabetes: Type 1 / Type 2
- ☐ Hearing impaired_____
- ☐ Heart—Abnormal EKG
- ☐ Heart—Atrial Fibrillation
- ☐ Heart—Angina
- ☐ Heart attack history _____
- ☐ Heart disease _____
- ☐ Heart Pacemaker
- ☐ Heart valve prosthesis
- ☐ Heart stent(s)
- ☐ Hepatitis—Type _____
- ☐ Hypoglycemia
- ☐ Kidney disease / failure / dialysis
- ☐ Liver disease _____
- ☐ Lung disease _____
- ☐ Mental Illness _____
- ☐ Metal plates / pins, etc. _____
- ☐ Myasthenia Gravis
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke _____
- ☐ Thyroid disease: Hyper / Hypo
- ☐ Tuberculosis
- ☐ Vision Impaired _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

MEDICAL INSURANCE INFORMATION

Include copies of most recent cards in file.

_____

Medical Insurance Company Name 1

Policy #_____

_____

Medical Insurance Company Name 2

Policy #_____

Medicaid #: _____

Medicare # _____

Veterans Admin # _____

Last four SSN # _____

ALLERGIES (CHECK ALL THAT APPLY)

- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Novocaine
- ☐ Opiods
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Ray Dyes
- ☐ Environmental_____
- ☐ Other _____