INDIVIDUAL HEALTH REVIEW

Name _____ Date of Birth _____

DRUG ALLERGIES/REACTIONS _____

_____

_____

_____

MEDICAL
CONDITIONS _____

_____

_____

_____

ALL MEDICATIONS AND SUPPLEMENTS TAKEN DAILY OR OCCASIONALLY
(Name, Dose, Directions)

_____

_____

_____

_____

DATE OF LAST VACCINATIONS
Tetanus _____ Pneumonia _____ Flu _____
Other _____

FAMILY DOCTOR/PRIMARY CARE PRACTITIONER
Name _____ Telephone _____
Address _____ Email _____

EMERGENCY CONTACT
Name _____ Telephone _____
Address _____ Email _____

INSURANCE COVERAGE
Medicare Claim # _____ Entitled to _____ Part A ____ Part B
OTHER COVERAGE
Name of Company _____ Policy # _____
Telephone # _____

LIVING WILL ____Yes _____No Are you an Organ Donor _____Yes ____No

DURABLE POWER OF ATTORNEY
Name _____ Telephone _____
Address _____

- *Carry a copy of your EKG, especially if it is abnormal*