Pharmacy Name: _____ Phone: _____

Allergies to Medications: _____

* Attach & date a separate page for additional medications or to record updates.

Medication	Dosage	Taken How Often? (Frequency)	Taken to treat what condition?	Located where in your home?

Current Medications:

_____

_____

Currently Being Treated For:

Name of Doctor: _____ Phone #: _____

Name of Doctor: _____ Phone #: _____

Current Medical Information

FOLD HERE – PLACE ON REFERIGERATOR – FOLD HERE

Date Completed: _____ **Updated:** _____ _____ _____ _____

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

Emergency Medical Information

In Case of Emergency, Please Notify:

Name: _____

Phone: _____ Relationship: _____

Street: _____ City: _____ State: _____

Medical CareAlert™
EMERGENCY RESPONSE SYSTEMS

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Emergency Medical Information

Medical CareAlert
EMERGENCY RESPONSE SYSTEMS

Basic Information

Name: _____

Male: _____ Female : _____ Height: _____ Weight: _____

Date of Birth: _____ Marital Status: _____

Hair Color: _____ Eye Color: _____ Blood Type: _____ Religion: _____

Primary Language Spoken: _____ Other Language(s): _____

_____ Glasses _____ Contact Lenses _____ False Teeth/Bridge

Hearing Aid: _____ Left _____ Right Deaf: _____ Left _____ Right

Blind: _____ Left _____ Right Artificial Eye: _____ Left _____ Right

Artificial Limbs or Prosthetic Devices: _____

Pacemaker Model #: _____ Defibrillator Model #: _____

Identifying Marks (i.e., birthmarks, tattoos, etc.): _____

Normal Blood Pressure: _____/_____ Smoker? _____

Medical History

Check Conditions that you have been treated for:

☐ Allergies	☐ Blood Pressure	☐ Epilepsy	☐ Insulin	☐ Stroke
☐ Anemia	☐ Cancer	☐ Glaucoma	☐ Jaundice	☐ Tuberculosis
☐ Arthritis	☐ Dementia	☐ Hay Fever	☐ Parkinson's Disease	
☐ Asthma	☐ Diabetes	☐ Heart Condition	☐ Sinus	

Hospital Information

Hospital Preference: _____ City: _____ State: _____

Last Hospitalization: _____ Hospital: _____ Date: _____ Treated For: _____

_____ Living Will If yes, location of Living Will: _____

_____ Do Not Resuscitate (DNR) Order Location of DNR: _____ Organ Donor: _____

Medical Insurance Coverage

Medicare #: _____ Medicaid #: _____

Other Policy # _____

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or call Customer Service 1-877-913-3680

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