



**Recent Surgery:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Do you have a Comfort Care / DNR form ?**

**YES**  **NO**  **Where is it located ?**

**MEDICAL CONDITIONS**

*Check all that exist*

- |   |  |
|---|--|
| <input type="checkbox"/> No known medical conditions  | <input type="checkbox"/> Hemodialysis          |
| <input type="checkbox"/> Abnormal EKG   | <input type="checkbox"/> Hemolytic Anemia      |
| <input type="checkbox"/> Adrenal Insufficiency  | <input type="checkbox"/> Hepatitis-Type [    ] |
| <input type="checkbox"/> Angina   | <input type="checkbox"/> Hypertension          |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Hypoglycemia          |
| <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Laryngectomy          |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Leukemia              |
| <input type="checkbox"/> Cardiac Dysrhythmia  | <input type="checkbox"/> Lymphomas             |
| <input type="checkbox"/> Cataracts  | <input type="checkbox"/> Memory Impaired       |
| <input type="checkbox"/> Clotting Disorder  | <input type="checkbox"/> Myasthenia Gravis     |
| <input type="checkbox"/> Coronary Bypass Graft  | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> | <input type="checkbox"/> Renal Failure         |
| <input type="checkbox"/> Diabetes/Insulin Dependent   | <input type="checkbox"/> Seizure Disorder      |
| <input type="checkbox"/> Eye Surgery  | <input type="checkbox"/> Sickle Cell Anemia    |
| <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Hearing Impaired   | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Heart Valve Prosthesis   | <input type="checkbox"/> Vision Impaired       |
| <input type="checkbox"/> Other: _____   |  |

**ALLERGIES**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Penicillin         |
| <input type="checkbox"/> Barbiturate    | <input type="checkbox"/> Latex         | <input type="checkbox"/> Sulfa              |
| <input type="checkbox"/> Codeine        | <input type="checkbox"/> Lidocaine     | <input type="checkbox"/> Tetracycline       |
| <input type="checkbox"/> Demerol        | <input type="checkbox"/> Morphine      | <input type="checkbox"/> X-Rays Dyes        |
| <input type="checkbox"/> Horse Serum    | <input type="checkbox"/> Novocaine     | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Environmental: |  |   |
| <input type="checkbox"/> Other: _____   |  |   |

**MEDICAL INSURANCE**

Med Ins Co: \_\_\_\_\_

Policy #: \_\_\_\_\_

Other Med Ins Co: \_\_\_\_\_

Policy #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Medicare #: \_\_\_\_\_