Medical Information – ________ Village, Hershey's Mill

PLEASE PRINT

Name: ___________________________________ **Address**: ______________________

Date Completed: ___________________________ **Date of Birth**: __________________

Emergency Contacts

Name: ___________________________________ Relationship: ________________________

Address: ____

Phone Number: ____

Primary Physician: ____

Other Physician: ________________________________ Specialty: ______________________

Other Physician: ________________________________ Specialty: ______________________

Medical Conditions – Check the Box or Boxes that Apply

Cardiac ☐ Atrial fibrillation ☐ Irregular Heart Rate ☐ Congestive heart failure ☐ Pacemaker ☐ Hypertension ☐ Angina ☐ None	☐ Anemia ☐ Anticoagulant use ☐ Renal failure **Endocrine** ☐ Diabetes (Type I or Type II) ☐ Thyroid abnormalities ☐ Adrenal Insufficiency or corticosteroid use
Pulmonary ☐ COPD ☐ Asthma ☐ None **Malignancy** (type) ______________________ ☐ None	**Neurology** ☐ Stroke or TIA ☐ Dementia ☐ Migraine Headaches ☐ Seizure Disorder ☐ Parkinson's Disease ☐ None
Ophthalmology ☐ Contact Lenses ☐ Cataract Lenses ☐ Glaucoma ☐ Vision impairment or blindness	**Gastrointestinal** ☐ Inflammatory Bowel Disease ☐ Gastrointestinal Bleeding ☐ None

Advance Directives or Living Will: ☐ Y ☐ N Power of Attorney: ☐ Y ☐ N

Health Care Proxy: ☐ Y ☐ N: Preferred Hospital or System: ____________________________

2-sided form – please complete the other side.

Other significant medical problems ☐ **None**

Medications: Name, frequency of administration, dosage ☐ **None**

Allergies/Reactions ☐ **None**

Surgery in last 5 years ☐ **None**

Other pertinent information

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