# 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

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

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

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## Allergies/Reactions ☐ None

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## Surgery in last 5 years ☐ None

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## Other pertinent information

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