**Medical Information Hershey’s Mill**

Click or tap here to enter text. **Village**

**Name**: Click or tap here to enter text. **Address**: Click or tap hereer text.

**Date Completed**: Click or tap here to enter text. **Date of Birth**: Click or tap here txt.

**Emergency Contacts**

Name: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

Primary Physician: Click or tap here to enter text.

Other Physician: Click or tap here to enter text.Specialty: Click or tap here to enter text.

Other Physician:Click or tap here to enter text. Specialty:Click or tap here to enter text.

**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:Click or tap here to enter text.

***2-sided form – please complete the other side.***

**Other significant medical problems** [ ] **None**

|  |  |
| --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Medications: Name, frequency of administration, dosage** [ ]  **None**

|  |  |
| --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Allergies/Reactions** [ ]  **None**

|  |  |
| --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Surgery in last 5 years** [ ]  **None**

|  |
| --- |
| Click or tap here to enter text. |
| Click or tap here to enter text. |
| Click or tap here to enter text. |
| Click or tap here to enter text. |
| Click or tap here to enter text. |

**Other pertinent information**

Click or tap here to enter text.