**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**

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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**

Click or tap here to enter text.