Medical Information – _____ Village, Hershey's Mill PLEASE PRINT

Name:	Address:
Date Completed:	
Emergence	y Contacts
Name:	Relationship:
Address:	
Phone Number:	
Primary Physician:	
Other Physician:	
Other Physician:	
Medical Conditions – Check	the Box or Boxes that Apply
Cardiac	□ Anemia
☐ Atrial fibrillation	☐ Anticoagulant use
□ Irregular Heart Rate	☐ Renal failure
☐ Congestive heart failure	
□ Pacemaker	Endocrine
☐ Hypertension	☐ Diabetes (Type I or Type II)
□ Angina	☐ Thyroid abnormalities
□ None	☐ Adrenal Insufficiency or corticosteroid use
Pulmonary	Neurology
□ COPD	☐ Stroke or TIA
□ Asthma	□ Dementia
□ None	☐ Migraine Headaches
	☐ Seizure Disorder
Malignancy (type)	☐ Parkinson's Disease
□ None	□ None
Ophthalmology	Gastrointestinal
☐ Contact Lenses ☐ Cataract Lenses	☐ Inflammatory Bowel Disease
□ Glaucoma	☐ Gastrointestinal Bleeding
☐ Vision impairment or blindness	□ None
Advance Directives or Living Will: \Box Y \Box N	Power of Attorney: □ Y □ N

<u>2-sided form – please complete the other side.</u>

Health Care Proxy: □ Y □ N: Preferred Hospital or System: _____

Other significant medical problems None		
Medications: Name, frequency of administration, dosage None		
Allergies/Reactions □ None		
L		
Surgery in last 5 years □ None		
Surgery in last 5 years ☐ None		
Other postinget information		
Other pertinent information		