VITALITY PT

Keep Information Up to Date

(use pencil)

Name:_____

Address:_____

_____

DOB:___/_____/_____

Emergency Contact(s)

Name:_____

Phone Number: (___)____-_____

Relation:_____

Name:_____

Phone Number: (___)____-_____

Relation:_____

Medical Data

Blood Type:_____

Doctor:_____

Phone Number: (___)____-_____

Preferred Hospital_____

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Recent Surgery (date)_____

_____

Living Will on File at:_____

Do you have EMS-NO CPR or a DNR Form?
___Yes , Where is it located:_____
___ No

Medical Conditions

__ No known conditions
__ Abnormal EKG
__ Adrenal Insufficiency
__ Angina
__ Asthma
__ Bleeding Disorder
__ Cancer
__ Cardiac Dysrhythmias
__ Cataracts
__ Clotting Disorder
__ Coronary Bypass Graft
__ Dementia __ Alzheimer
__ Diabetes/Insulin Dependent
__ Glaucoma
__ Hearing Impaired
__ Heart Valve Replacement
__ Hemodialysis
__ Hemolytic Anemia
__ Hepatitis [__]
__ Hypertension
__ Hypoglycemia
__ Leukemia
__ Lymphomas
__ Memory Impaired
__ Myasthenia Gravis
__ Pacemaker
__ Renal Failure
__ Seizure Disorder
__ Sickle Cell Anemia
__ Stroke
__ Tuberculosis
__ Vision Impaired

Other:_____

Allergies

__ Aspirin
__ Barbituate
__ Codeine
__ Demerol
__ Horse Serum
__ Insect Stings
__ Latex
__ Lidocaine
__ Morphine
__ Novocaine
__ Penicillin
__ Tetracycline
__ Xray Dyes
__ No Known Allergies

Other:_____

Medical Insurance

Med Ins Co:_____
Policy #_____
Other Med Ins Co:_____
Policy #_____
Medicare #_____
Medicaid #_____