Community Housing Management Network

MEDICAL INFORMATION FORM

IN CASE OF MEDICAL EMERGENCY CALL 911

PERSONAL INFORMATION

First Name: _____ **Last Name:** _____

Address: _____ **Apartment Number:** _____

City: _____ **Postal Code:** __ __ __ __ __ __

Main Phone: (__ __ __) __ __ __ - __ __ __ __ **Alt. Phone:** (__ __ __) __ __ __ - __ __ __ __

Health Card: _____
** leave a copy in the envelope*

Birth Date: ___ ___ / ___ ___ / ___ ___ ___ ___
Day Month Year

Primary Language(s): _____ **Gender:** ☐ **M** ☐ **F**

☐ **Advanced Care Directive** ⇨ **On file with:** _____

CONTACT INFORMATION

Primary Care Provider: _____

Phone: (__ __ __) __ __ __ - __ __ __ __

Emergency Contact 1: _____

Main Phone: (__ __ __) __ __ __ - __ __ __ __ **Alt. Phone:** (__ __ __) __ __ __ - __ __ __ __

Emergency Contact 2: _____

Main Phone: (__ __ __) __ __ __ - __ __ __ __ **Alt. Phone:** (__ __ __) __ __ __ - __ __ __ __

MEDICAL CONDITIONS

Select all that apply:

☐ **Cardiac** (angina, heart attack, bypass, pacemaker)
Date: _____

☐ **Diabetic** (Insulin/non-insulin dependent)

☐ **Cancer**
☐ **Remission**
☐ **Chemo/Radiation**

☐ **Stroke/TIA**
Date: _____

☐ **COPD** (emphysema, bronchitis)

☐ **Alzheimer**

☐ **Hypertension** (high blood pressure)

☐ **Seizure** (convulsions)

☐ **Dementia**

☐ **Congestive heart failure**

☐ **Asthma**

☐ **Psychiatric**

☐ **Communicable Infection/Disease** (HIV/AIDS, Hepatitis, etc.) _____

MEDICATIONS

Include all medications you take daily. Prescribed by a health care provider or self-prescribed, such as vitamins, herbs or dietary supplements.

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____

10) _____ 11) _____ 12) _____

MEDICAL ALLERGIES

☐ **No Known Allergies** ☐ **Penicillin** ☐ **ASA** (Aspirin) ☐ **Sulpha** ☐ **Codeine**

Other: _____

Do Not Resuscitate Form (DNR)

Do you have a DNR in place? ☐ **Yes, a copy is included** ☐ **No**

*More information can be discussed with your family doctor

MOBILITY / SENSORY

☐ **Dentures** ☐ **Visual** (impairment/glasses/contact lenses/blind) ☐ **Hearing** (impairment/aid/deaf)

☐ **Mobility issues** (cane/wheelchair/walker/motorized scooter/prosthetic limb) ☐ **Oxygen tank**

PET CARE CONTACTS

Contact 1: _____ **Phone:** (__ __ __) __ __ __ - __ __ __ __

Contact 2: _____ **Phone:** (__ __ __) __ __ __ - __ __ __ __

List of pets and pet care instructions: _____

_____

_____

Completed by: _____ **Date:** ___ ___ / ___ ___ / ___ ___ ___ ___

Day **Month** **Year**