Personal Emergency Information
www.LakesideEmergencyInfo.weebly.com

7. Medical and Health Information

Use this form to document your personal medical and health insurance data and to list your doctors and caregivers.
IMPORTANT: *After you complete the form, print it and store it in a safe place in your house.*

Today's Date:

A. Your Personal Medical Profile

Name:

Date of Birth: **Blood Type:**

B. Your Personal Physician

Name:

Cell Phone Number: **Office Phone Number**

Address:

Specialty: **Hospital Preference:**

C. Your Specialty Caregivers

Name (1):

Cell Phone Number: **Office Phone Number**

Address:

Specialty: **Hospital Preference:**

Notes:

Name (2):

Cell Phone Number: **Office Phone Number**

Address:

Specialty: **Hospital Preference:**

Notes:

Name (3):

Cell Phone Number: **Office Phone Number**

Address:

Specialty: **Hospital Preference:**

Notes:

7. Medical and Health Information (continued)

D. Medications You Take Regularly

List important medications you must take regularly (e.g., for diabetes, high blood pressure, high cholesterol, glaucoma, etc.).

Today's Date:

Medication (1):
Purpose (Diagnosis): **Dosage:**
Prescribing Physician:

Medication (2):
Purpose (Diagnosis): **Dosage:**
Prescribing Physician:

Medication (3):
Purpose (Diagnosis): **Dosage:**
Prescribing Physician:

Medication (4):
Purpose (Diagnosis): **Dosage:**
Prescribing Physician:

Medication (5):
Purpose (Diagnosis): **Dosage:**
Prescribing Physician:

Medication (6):
Purpose (Diagnosis): **Dosage:**
Prescribing Physician:

Notes:

E. Medical Devices and Implants

List here such items as heart pacemakers, gastric bands, artificial hips or other limbs, colostomy, breast implants, etc.

Device (1):
Purpose (Diagnosis): **Date initiated:**

Device (2):
Purpose (Diagnosis): **Date initiated:**

Device (3):
Purpose (Diagnosis): **Date initiated:**

Notes:

7. Medical and Health Information (continued)

Personal Emergency Information
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F. Private Health Insurance Information

Today's Date:

Policyholder (1):

Address:

Agent Name **Phone:**

Issuer: **Policy No.:**

Phone for Approvals:

Policyholder (2):

Address:

Agent Name **Phone:**

Issuer: **Policy No.:**

Phone for Approvals:

G. IMSS (Mexican National Health Insurance) Information

Registered Name:

Registered Address:

NSS No.: **R.P. No.:**

Calidad No.: **Exp. Date:**

H. Life Insurance Information

Policyholder (1):

Address:

Agent Name **Phone:**

Issuer: **Policy No.:**

Policyholder (2):

Address:

Agent Name **Phone:**

Issuer: **Policy No.:**