



**Personal Information**

**Date form Completed** \_\_\_\_\_

Name:	Date of Birth:	Age:
Address:	Gender: Male Female	
City & Zip:	SSN#: (Optional)	
Phone:	Weight:	
Emergency Contact Name	Emergency Contact Phone:	
Physician Name	Physician Phone:	

**Medical Information**

Do you have an active and signed Do Not Resuscitate (DNR) (***If yes, please attach!***) Yes No  
 Do you have an Advance Health Care Directive? Yes No  
 Do you have some one who legally makes your medical decisions? Yes No  
 If yes, whom? \_\_\_\_\_ Relationship \_\_\_\_\_  
 Phone number for person stated on line above \_\_\_\_\_  
 Blood Type: \_\_\_\_\_ Religious Preference \_\_\_\_\_  
 Are you an organ donor? Yes No

**Medical Conditions: Check all that apply** ✓

AIDS / HIV	Epilepsy
Anxiety	Heart Attack: Year Occurred( )
Asthma	Hepatitis (A) (B) (C) (D) (E) (F) (G)
Cancer	High Blood Pressure
CHF	Irregular Heart Beat
COPD	Pacemaker
Diabetes	Stroke
Emphysema	Thyroid

**Other Major Medical conditions not listed**


