Proactive Health Advocates
Helping You Navigate Your Healthcare

Emergency Medical Information Form

The Emergency Medical Form is a good way to provide emergency personnel and other healthcare providers with your most important health information. This form is a pdf document that you can fill in on your computer or if you prefer, print off and complete.

To ensure you can fill in the form on your computer, download the form to your computer and then open it in Adobe Reader (version 9 or higher), which is free to download from the internet.

Either way you decide to complete the form, remember to update your information as it changes.

We recommend you place your form and copies of other documents (see below) in a folder and put it in an easy to grab location. If you prefer to keep your information on a thumb drive, make sure it is you place it in an envelope that is clearly labeled as emergency health information. In addition, we recommend you give your family or anyone who may be called on for information if you are incapacitated, copies of these documents.

Other documents to include in your folder:

- Copies of your Advance Directive, Medical Power of Attorney, Durable Do not Resuscitate form, etc.
- Copy of your insurance cards, front and back

Feel free to share the Emergency Medical Information form with others

Certified by the Patient Advocate Certification Board™

Proud Member of The Alliance of Professional Health Advocates
www.APHAdvocates.org

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Greater National Advocates
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If you need help navigating your healthcare, or the healthcare of a loved one, please call us for a no cost, 20 minute, consultation.

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Emergency Medical Information

Date Last Updated _____

Name _____ Date of Birth _____
Address _____ City _____
State _____ Zip Code _____ Gender _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____

Medical Conditions

- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Alzheimer's/Dementia
- ☐ Heart Disease
- ☐ Asthma
- ☐ Anxiety
- ☐ Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Stroke
- ☐ Epilepsy
- ☐ Autoimmune Disorder
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Assistive Devices

- ☐ Dentures
- ☐ Glasses
- ☐ Contacts
- ☐ Hearing Aids
- ☐ Other _____
- ☐ Other _____

Allergies (medication, food, other)

Medication List (include prescription and over-the-counter)

Medication Name	Dose	Frequency	Reason for Taking

Your Name _____ (Page 2)

Hospitalizations (why**)/Surgeries (**what**)** (list most recent first)

Hospitalization (why) /Surgery (what)	Year	Hospital/Facility

Physicians

	Name	Specialty	Name of Practice	Phone
PCP				
Specialist				
Specialist				
Specialist				
Specialist				

Pharmacy

Name _____ Address _____ Phone _____

Emergency Contacts

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Legal Documents

Healthcare Power of Attorney/Healthcare Proxy			☐	Yes	☐ No
If Yes: Name		Relationship		Phone	
Advance Directive			☐	Yes	☐ No
Do Not Resuscitate Order			☐	Yes	☐ No
POLST			☐	Yes	☐ No

Insurance

Medicare	☐	Yes	☐	No	Medicare #		
Medicare Supplement	☐	Yes	☐	No	Medicare Supplement #		
Medicare Part D	☐	Yes	☐	No	Medicare Part D #		
Other Insurance	☐	Yes	☐	No	Insurance Company		
Policy Holder:					Relationship		
Member ID #							

Important Things to Know About Me