Coastal Empire Polio Survivors Association, Inc.
Health Data Form

Patient Name _____Date of Birth _____Sex: ____M ____F

Address _____

_____

Phone Number ( ) _____Cell Number ( ) _____

Next of Kin _____
Name Relationship Phone Number

Other Contacts_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

Living Arrangements (e.g., living alone):_____

Church Affiliation: _____
Church Clergyperson Phone Number

Primary Insurance _____
Company Phone Number Policy Number

_____
Insured Name Relationship to Patient

Secondary Insurance _____
Company Phone Number Policy Number

_____
Insured Name Relationship to Patient

Hospital Preferred/Required: _____

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Advance Directives: Check all that apply.

Living Will _____ Durable Power of Attorney for Healthcare _____ Attached _____
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List all individuals who may receive information about your condition upon request:

Name	Relationship	Phone Number

List all individuals who are restricted from receiving information regarding your condition:

Name	Relationship		Name	Relationship

Physicians (All who are treating you):

Physician Name	Phone Number		Physician Name	Phone Number
Primary Physician				

Current Diagnoses:

Past Medical and Surgical History (Include polio – age, type, treatment, etc.):

Diagnoses and Surgeries		Diagnoses and Surgeries

Medications (Include over the counter medications, vitamins and supplements)

Preferred Pharmacy _____Phone Number _____

Drug (e.g., Tylenol)	Strength (e.g.,500 mg)	Dosage (e.g., 2 tablets)	Instructions (e.g., every 4 hrs)	For What (e.g., Pain)

List Year of Last Immunizations Flu_____ Pneumonia_____Tetanus_____

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Allergies and Side Effects (Incl. Foods, Chemicals, and Other Materials)

Agent (e.g. Penicillin)	Reaction (e.g. Rash)		Agent (e.g. Tape)	Reaction (e.g. Blister)

Other Treatments (e.g., Oxygen, Sitz Bath, etc.)

Treatment	Instructions

List all implanted medical devices (e.g. Pacemaker, Stents, Shunts)

Special Accommodations (e.g., elevate head of bed when sleeping or pillow under knees)

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Special needs (e.g. Low vision or non-ambulatory – uses wheelchair or scooter)

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Adaptive Equipment (e.g. Cane, Brace, Crutches)

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Organ/Body Donor: No __ Yes __ If Yes, please list contact information

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Patient Signature _____Date_____

Witness Signature_____Date_____