

VITAL HEALTH RECORDS for _____
updated on _____ / _____ / _____ **by** _____

PLEASE USE A PENCIL TO COMPLETE THIS FORM

Remember to update this form whenever there is a change in information.

Name _____ Home phone () _____ - _____ Male Female
 Address _____ City _____ State _____ Zip _____
 Date of birth: _____ / _____ / _____ Place of birth: _____
 People living at this address: _____ adults _____ children Pets: How many? _____ Cat _____ Dog _____
 I speak _____ / understand _____ / read _____ English. Other languages spoken: _____
 Education level: Elementary _____ High School _____ College _____ Occupation _____

MEDICAL HISTORY

Conditions treated for:
 Anemia Cancer Stroke Blood Pressure Memory loss
 Asthma Head injury Swallowing problems Heart Condition _____
 Pacemaker yes no Implanted defibrillator yes no
 Diabetic yes no Insulin dependent yes no
 Dialysis yes no If yes, dialysis location _____
 Normal blood pressure _____ / _____ Last Tetanus shot _____ / _____ Medic alert tag yes no
 Major illnesses _____ Surgeries _____

MEDICATIONS

NOTE: Keep ALL prescriptions in one place so emergency responders can locate them quickly.
 Location of medications (prescriptions and non-prescriptions) _____
 Location of supplements, vitamins etc. _____
 Pharmacy is _____ Phone () _____ - _____
 The person who knows my current prescription information
 Name _____ Relationship _____ Phone () _____ - _____

ALLERGY INFORMATION

I have the following allergies:
 Medications _____ Latex yes no
 Insect bites _____ Epi Pen yes no
 Foods _____ Pollen _____ Chemicals _____
 Other _____

ADDITIONAL IMPORTANT INFORMATION

Medicare # _____	Living Will <input type="checkbox"/> yes <input type="checkbox"/> no
Medicaid # _____	Durable Power of Attorney for Health Care <input type="checkbox"/> yes <input type="checkbox"/> no
Private Insurance provider _____	Name _____ Phone _____
Policy # _____	DNR (Do Not Resuscitate) <input type="checkbox"/> yes <input type="checkbox"/> no
Guardianship <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, DNR for <input type="checkbox"/> Arrest <input type="checkbox"/> Comfort Care
Guardian's name _____	Location of DNR _____
Phone () _____ - _____	Religious affiliation _____
Agencies involved in my care _____	Please contact _____
_____	Special instructions in case of an emergency _____
_____	_____
_____	_____

EMERGENCY CONTACTS

NAME	CITY/STATE	RELATIONSHIP	PHONE
_____	_____	_____	() _____ - _____
_____	_____	_____	() _____ - _____
_____	_____	_____	() _____ - _____

MY MEDICAL PROVIDERS

	Primary	Other	Other
Physician	_____	_____	_____
Medical specialty	_____	_____	_____
City	_____	_____	_____
Telephone	_____	_____	_____

Hospital choice: Akron City Akron General Children's Cuyahoga Falls St. Thomas

**The following information will enable better communication in the case of an emergency.
Please check all the areas that best describe your present situation.**

AMBULATION - WALKING AID

- _____ I walk with a cane
- _____ I use a walker
- _____ I need someone to walk with me
- _____ I use a wheelchair
- _____ I am unable to walk

VISION

- _____ I need large print
- _____ I wear glasses/contact lenses
- _____ I need glasses/contact lenses for reading
- _____ Glaucoma
- _____ Macular degeneration
- _____ Cataracts
- _____ I neglect objects on: _ right side _ left side
- _____ Legally blind
- _____ Need bright light
- _____ Glare and lights are bothersome

HEARING

- _____ I have a severe hearing loss
- _____ I am able to read lips
- _____ I understand and use sign language
- _____ I wear hearing aids _____ right _____ left
- _____ Please write out the information
- _____ Gestures are helpful
- _____ I am sensitive to loud noises

COMPREHENSION

- _____ I have trouble understanding sentences that are spoken to me
- _____ I have trouble remembering things spoken to me
- _____ I have trouble reading sentences
- _____ I have trouble following complex directions
- _____ Too much information at one time confuses me
- _____ Too much background noise makes it harder to understand/concentrate

SPEECH

- _____ My speech is difficult to understand
- _____ My speech is impaired from a previous stroke
- _____ I have a communication chart
- _____ I have a communication devise
- _____ Ask me yes or no questions
- _____ I have trouble saying the correct word
- _____ I sometimes say the incorrect word
- _____ I have trouble explaining or describing details
- _____ Writing out the information is helpful

MEMORY

- _____ Speak slower
- _____ Use short sentences
- _____ Please write out the information
- _____ I need one step directions
- _____ I have trouble thinking of words
- _____ I have trouble explaining more complex thoughts
- _____ Gestures are helpful
- _____ Give me two word choices
- _____ Ask me yes or no questions
- _____ When there is too much stimulation
- _____ I get upset or agitated
- _____ Sometimes I get confused

In signing this I agree that any information as reported on my **VITAL HEALTH RECORDS** may be used by emergency responders (Police/Fire/EMS) and conveyed to hospital emergency department staff in order to better respond to my health emergency.

Signature: _____

I am enrolled in the
Safe Return Program
Please call: **1-800-572-1122**
24 hours a day to file a report

I have a history of wandering yes no
Places where I may have wandered to:

I am a caregiver for _____
who cannot be left alone.

In case of an emergency contact:
Name _____
Address _____
Phone _____

FOR ADDITIONAL FORMS
AND INFORMATION
CONTACT ANY
VITAL HEALTH RECORDS' SPONSOR.