Medical Information Form

Post completed form on your refrigerator in case of an emergency

Public Health
Prevent. Promote. Protect.

Ashland County Health Department

DATE COMPLETED:		**DATE UPDATED:**	
FIRST NAME	**MIDDLE INITIAL**	**LAST NAME**	
STREET	**CITY**	**STATE**	**ZIP CODE**
TELEPHONE		**PETS IN HOME** (#, type, and names):	
DATE OF BIRTH	MALE ☐ FEMALE ☐	***PRIMARY INSURANCE**:	EXPIRATION DATE
PRIMARY LANGUAGE:		**SECONDARY INSURANCE**:	EXPIRATION DATE
UNABLE TO SPEAK ☐	**RELIGION**:	**OTHER INSURANCE**:	EXPIRATION DATE
HEARING DIFFICULTIES: HEARING AIDS: YES ☐ NO ☐		**VISION DIFFICULTIES**: GLASSES ☐ CONTACTS ☐	**DENTURES:** UPPER ☐ LOWER ☐

HEIGHT	**WEIGHT**	**HAIR COLOR**	**EYE COLOR**	**BLOOD TYPE**

IDENTIFYING MARKS (SCARS, MOLES, TATTOOS, ETC.):

CURRENT MEDICAL CONDITIONS:	**1.**
	2.
	3.
	4.
	5.
	6.

CURRENT MEDICATIONS:	**MEDICATION NAME:**	**DOSE**	**FREQUENCY**
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		

ALLERGIES (MEDICATIONS AND FOOD)	**1.**
	2.
	3.
	4.
	5.

*We recommend you include a copy of your insurance card with this form

Form continues on the back

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PHYSICIANS & PHARMACY INFORMATION	
FAMILY DOCTOR NAME: PHONE NUMBER:	**PHARMACY** NAME: PHONE NUMBER:
SPECIALIST: NAME: PHONE NUMBER:	**SPECIALIST:** NAME: PHONE NUMBER:
SPECIALIST: NAME: PHONE NUMBER:	**SPECIALIST:** NAME: PHONE NUMBER:

PAST MEDICAL CONDITIONS OR SURGERIES:	**1.**
	2.
	3.
	4.
	5.
	6.
SPECIAL INSTRUCTIONS (Living Wills, Durable Power of Attorney, etc.):	

EMERGENCY CONTACTS		
NEXT OF KIN	NAME:	RELATIONSHIP:
	ADDRESS:	TELEPHONE NUMBER:
	NAME:	RELATIONSHIP:
	ADDRESS:	TELEPHONE NUMBER:
	NAME:	RELATIONSHIP:
	ADDRESS:	TELEPHONE NUMBER: