

EMERGENCY CONTACT:

Name:

Address:

Home Phone #:

Work Phone#:

Do you have any of the following:

1. Out-of-Hospital Do Not Resuscitate (OOHDNR) Directive? Yes No

2. Advanced Directives/Living Will? Yes No

3. Power of Attorney (POA) for Healthcare? Yes No

Name of POA:

MEDICAL CONDITIONS

Check all that exist

<input type="checkbox"/> No known medical condition	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Adrenal insufficiency	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Valve Prosthesis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cancer/Leukemia/lymphoma	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> CHF	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Pacemaker/AID (defibrillator)
<input type="checkbox"/> Coronary Bypass Graft	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Dementia	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Stroke
<input type="checkbox"/> GERD or Reflux Disease	
<input type="checkbox"/> Surgeries-Please List	<input type="checkbox"/> Implants-Please List:

ALLERGIES

Latex

Others:

VACCINATIONS

Pneumonia Date: Others:

Flu Date:

Tetanus Date:

**Please Copy both sides of your Health Insurance
and/or Medicare/Medicaid card and Attach the
Copy to this form.**

This form may also be obtained from the Boone County Hospital
Website at www.boonehospital.com