ORDER OF CARMELITES
EMERGENCY MEDICAL DATA

You are encouraged as best you can to complete these medical forms. Then, place them in an envelope along with any other legal documents relating to your care, such as Living Wills, Durable Power of Attorney Forms, etc. in a clearly marked "Emergency Medical Data" envelope on the inside of your door. You should also consider leaving a copy somewhere else in your house, such as with your Prior. In case an emergency occurs, especially if you are unable to speak, this information will contribute significantly to your well being and care. Please remember to update it anytime there are significant changes.

Name: _____ Date: _____

Age: _____ Birthdate: _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____ Race: _____

Identifying marks: _____

Social Security # _____ Medicare # _____

Primary Insurance Company: _____

Policy # _____ Phone: _____

Supplemental Insurer: _____

Policy # _____ Phone: _____

Benefit approval phone (if different): _____

Your doctor's name: _____ Phone: _____

Address: _____ City: _____

Alternate doctor: _____ Phone: _____

Hospital preference: _____ Location: _____

Have you filled out a Durable Power of Attorney for Health Care form or a Living Will form? ☐ Yes ☐ No

Where are the copies? _____

Are copies on file at Provincial office? ☐ Yes ☐ No Phone: (630) 971-0050

Emergency Contact: _____ Relationship: _____

Phone – Home: _____ Work: _____ Cell/Pager: _____

Emergency Contact: _____ Relationship: _____

Phone – Home: _____ Work: _____ Cell/Pager: _____

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Phone – Home: _____ Work: _____ Cell/Pager: _____

MEDICAL INFORMATION

Please indicate what medicine(s) you're taking, what the dosage is, how often you take the medicine(s) and where you keep it/them. (i.e.: refrigerator, kitchen counter, medicine cabinet, nightstand, etc.)

Prescription Medications:

Name	Dosage	How Often	Where Kept
(Example: Elixir	*50 mg*	*Daily*	*Kitchen Cabinet)*

Non-prescription medications taken regularly, including aspirin or ibuprofen:

Name	Dosage	How Often	Where Kept

Do you take vitamins/herbs?

Name	Dosage	How Often	Where Kept

Inoculations:

Have you had a Tetanus shot? ☐ Yes ☐ No

When: _____ Reactions: _____

Have you had a Flu shot? ☐ Yes ☐ No

When: _____ Reactions: _____

Other Shots: _____ When: _____

Allergies and Reactions:

Drug Allergies? _____ Type of Reaction: _____

Food Allergies? _____ Type of Reaction: _____

Any past complications with anesthesia? _____

Health Status: (Check all that apply)

☐ Heart problems ☐ Heart attack ☐ Stroke ☐ Diabetes

☐ High blood pressure ☐ Alzheimer's ☐ Cancer ☐ Parkinson's

☐ Other _____

Do you wear:

☐ Contact Lenses ☐ Glasses ☐ Glass Eye ☐ Hearing aid(s)

☐ Dentures/Bridge/Caps ☐ Use Oxygen ☐ Use a cane or walker

☐ Have Chronic EKG abnormalities? ☐ Other: _____

Are you actively being treated at this time for TB? ☐ Yes ☐ No

Blood Type: _____

Past surgeries:

Type: _____ When: _____

Type: _____ When: _____

Type: _____ When: _____

Type: _____ When: _____

Type: _____ When: _____

Type: _____ When: _____

Have you made the choice to donate your organs? ☐ Yes ☐ No

☐ All ☐ Some ☐ Specify: _____

Are mortuary arrangements on file with the Provincial Office? ☐ Yes ☐ No

Do you have pets? ☐ Dog ☐ Cat ☐ Other _____

Where is the animal(s) _____ Special Information: _____

Who should be called to care for your pet? _____ Phone: _____

Date this form was completed: _____

Date completed/revised: _____

Other pertinent information: _____