CRAWFORD COUNTY MEMORIAL HOSPITAL

EMERGENCY MEDICAL INFORMATION

BASIC INFORMATION

Name: _____

Male: _____ Female: _____ Height: _____ Weight: _____

Date of Birth: _____ Marital Status: _____

Hair Color: _____ Eye Color: _____ Blood Type: _____ Religion: _____

Primary Language Spoken: _____ Other Language(s): _____

☐ Glasses ☐ Contact Lenses ☐ False Teeth / Bridge

Hearing Aid: ☐ Left ☐ Right Deaf: ☐ Left ☐ Right

Blind: ☐ Left ☐ Right Artificial Eye: ☐ Left ☐ Right

Artificial Limbs or Prosthetic Devices: _____

Pacemaker Model #: _____ Defibrillator Model #: _____

Identifying Marks (i.e., birthmarks, tattoos, etc.): _____

Normal Blood Pressure: _____ / _____ Smoker? _____

MEDICAL HISTORY

Check Conditions that you have been treated for:

☐ Allergies	☐ Blood Pressure	☐ Epilepsy	☐ Insulin	☐ Stroke
☐ Anemia	☐ Cancer	☐ Glaucoma	☐ Jaundice	☐ Tuberculosis
☐ Arthritis	☐ Dementia	☐ Hay Fever	☐ Parkinson's Disease	
☐ Asthma	☐ Diabetes	☐ Heart Condition	☐ Sinus	

HOSPITAL INFORMATION

Hospital Preference: _____ City: _____ State: _____

Last Hospitalization: _____ Hospital: _____

Date: _____ Treated For: _____

☐ Living Will If yes, location of Living Will: _____

☐ Do Not Resuscitate (DNR) Order Location of DNR: _____ Organ Donor: _____

MEDICAL INSURANCE COVERAGE

Medicare #: _____ Medicaid #: _____

Other Policy #: _____

Need another copy? Download at **www.ccmhia.com/medical-services/emergency** or call the CCMH Emergency Department at **712-265-2500**

BE SURE TO COMPLETE REVERSE SIDE

CRAWFORD COUNTY MEMORIAL HOSPITAL

BE SURE TO COMPLETE REVERSE SIDE

In Case of Emergency, Please Notify:

Name: _____

Phone: _____ Relationship: _____

Street: _____ City: _____ State: _____

EMERGENCY MEDICAL INFORMATION

Name: _____

Date Completed: _____ Updated: _____

Street : _____

City: _____ State: _____ Zip: _____

Phone: _____

FOLD HERE – PLACE ON REFRIGERATOR – FOLD HERE

Current Medical Information

Name of Doctor: _____ Phone #: _____

Name of Doctor: _____ Phone #: _____

Currently Being Treated For: _____

_____

Current Medications:

Medication	Dosage	Taken How Often? (Frequency)	Taken to treat what condition?	Located where in your home?

* Attach & date a separate page for additional medications or to record updates.

Allergies to Medications: _____

Pharmacy Name: _____ Phone #: _____