

# Lake Chapala End-of-Life Care Community

## Emergency Information Form 4 - Medical Information

Date Form Filled Out \_\_\_\_\_

Your Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex: ☐ Male/Masculino ☐ Female/Femenino Blood Type / Typo de Sangre \_\_\_\_\_

Address \_\_\_\_\_ House Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Primary Care Physician

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_

☐ I have a **Mexican** Medical Directive

☐ I am a registered Organ Donor

Preferred Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Ambulance \_\_\_\_\_ Phone \_\_\_\_\_

### Your Health Insurance

Company Name \_\_\_\_\_ Phone \_\_\_\_\_ Account \_\_\_\_\_

List medications you must take regularly – for conditions such as diabetes, high blood pressure, high cholesterol, glaucoma, mental health, etc.

- If there are vitamins or other supplements that you **MUST** continue to take if you are hospitalized, include them on this list.
- With the Medication Name, list the generic name if possible.

| Medication / Diagnosis | Dose | Times per Day |
|------------------------|------|---------------|
|                        |      |               |
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|                        |      |               |

### Doctors and Specialists

Doctor \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_

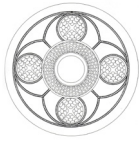
Doctor \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_



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Check the box if you have any of the health conditions listed below. (For consistency, the numbers are the same as the Cruz Roja form.)

### Serious Conditions

- ☐ 1. Allergies to Medications or other Allergies
- ☐ 2. I take Anti-Coagulant (Blood Thinners)
- ☐ 3. Diabetes
- ☐ 4. Cardiac/Heart Problems
- ☐ 5. Abnormal Blood Pressure (High or Low)
- ☐ 6. Cirrhosis or other Liver Problems
- ☐ 7. Stroke, Cerebral Clot or Hemorrhage
- ☐ 8. Epilepsy
- ☐ 9. Asthma
- ☐ 10. Other Serious Condition -- Specify below.

### Infectious Conditions

- ☐ 11. Tuberculosis
- ☐ 12. HIV / AIDS
- ☐ 13. Hepatitis Specify A, B, C or D \_\_\_\_\_
- ☐ 14. Other Infection Condition --Specify below.

### Chronic Conditions

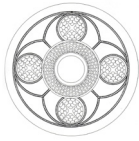
- ☐ 15. Blindness
- ☐ 16. Hearing Problems
- ☐ 17. Speech or Communication Problems
- ☐ 18. Mobility Problems
- ☐ 19. Kidney Problems
- ☐ 20. Liver Problems
- ☐ 21. Thyroid Problems
- ☐ 22. Parkinson's Disease
- ☐ 23. Alzheimer's Disease or Other Dementia
- ☐ 24. Cancer -- Specify Below
- ☐ 25. Lung Problems
- ☐ 26. Psychological Problems
- ☐ 27. Autoimmune Disease
- ☐ 28. Alcohol or Street Drug Use/Addiction
- ☐ 29. Other Chronic Problem -- Specify below.

If you answered YES to any of the items above, add more information in the sections below, referring to the item/condition number.

| # | Condition | Year |
|---|-----------|------|
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Check the items that you use regularly. These are things you would need with you if you were hospitalized.

- |                                              |                                            |       |
|----------------------------------------------|--------------------------------------------|-------|
| <input type="checkbox"/> Eye Glasses         | <input type="checkbox"/> CPAP Machine      | _____ |
| <input type="checkbox"/> Contact Lenses      | <input type="checkbox"/> Dentures/Bridges  | _____ |
| <input type="checkbox"/> Hearing Aids        | <input type="checkbox"/> Compression Socks | _____ |
| <input type="checkbox"/> Oxygen Concentrator | <input type="checkbox"/> Special Shoes     | _____ |



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## Emergency Information Form 4 - Medical Information

Add your Surgical History here.

| Year | Surgery Description |
|------|---------------------|
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List any implants or items that doctors or surgeons need to know about before you have surgery or scan, such as heart pacemakers, gastric bands, artificial hips or other joints, colostomy, breast implants, metal plates used to repair broken bones, etc.

If you were asked to name a "beneficiary" for insurance reimbursement or other financial benefits related to your implant, list that person for each device.

**Device/Implant** \_\_\_\_\_ Purpose/Diagnosis \_\_\_\_\_  
Date of Implant \_\_\_\_\_ Notes \_\_\_\_\_  
Beneficiary \_\_\_\_\_

**Device/Implant** \_\_\_\_\_ Purpose/Diagnosis \_\_\_\_\_  
Date of Implant \_\_\_\_\_ Notes \_\_\_\_\_  
Beneficiary \_\_\_\_\_

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Date of Implant \_\_\_\_\_ Notes \_\_\_\_\_  
Beneficiary \_\_\_\_\_

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Date of Implant \_\_\_\_\_ Notes \_\_\_\_\_  
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Beneficiary \_\_\_\_\_