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

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 Hemmorage
- ☐ 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 Dimentia
- ☐ 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 itmes above, add more information in the sections below, referring to the item/condition number.

#	Condition	Year

Check the items that you use regularly. These are things you would need with you if you were hospitalized.

- ☐ Eye Glasses
- ☐ Contact Lenses
- ☐ Hearing Aids
- ☐ Oxygen Concentrator
- ☐ CPAP Machine
- ☐ Dentures/Bridges
- ☐ Compression Socks
- ☐ Special Shoes

_____
_____
_____
_____

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Add your Surgical History here.

Year	Surgery Description

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, artifical 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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