Saint Vincent Hospital

Conversations Across the Lifespan
Personal Medical Records

Name_____
(Last) *(First)* *(Middle)*

Birth Date _____ Blood Type_____

Emergency Contact Phone Number(s)

Name_____ Phone Number _____

Name_____ Phone Number _____

Name_____ Phone Number _____

Personal Physician

Name_____ Phone Number _____

Dentist

Name_____ Phone Number _____

Eye Doctor

Name_____ Phone Number _____

Other

Name_____ Phone Number _____

Health Insurance

Carrier _____

Group Number Agreement _____

Number_____

List all CURRENT MEDICAL CONDITIONS (Attach additional conditions to document)

_____

_____

_____

List SURGERIES and dates (In the last 5 years)

_____

_____

_____

Saint Vincent Hospital

List all current medications, prescription and nonprescription (with dosage)
(Attach additional information to this document or list on the back of this page)

_____

_____

_____

List all ALLERGIES AND DRUG SENSITIVITIES (Describe)

_____

_____

_____

Have you ever been told you had one of the following?

Lung disorder ❑ Yes ❑ No
Kidney disease ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Malaria ❑ Yes ❑ No
High blood pressure ❑ Yes ❑ No
Heart trouble ❑ Yes ❑ No
Nervous disorder ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No
Disease/disorder of digestive tract ❑ Yes ❑ No

Disease/disorder of the blood? ❑ Yes ❑ No (describe) _____

Any physical defect or deformity? ❑ Yes ❑ No (describe)_____

Any vision or hearing disorders? ❑ Yes ❑ No (describe) _____

Any cancer? ❑ Yes ❑ No (describe) _____

Any heart procedures in the last 5 years? ❑ Yes ❑ No (describe) _____

Date of last PHYSICAL _____ **Date of last TETANUS SHOT** _____

Date of last Flu Shot _____ **Date of last Pneumonia Vaccine**_____

Blood Pressure

Date_____Pressure_____ Date_____Pressure_____ Date_____Pressure_____

Date_____Pressure_____ Date_____Pressure_____ Date_____Pressure_____

Family History (List your important family medical problems)

Mother _____

Father _____

Other_____