



Emergency Medical Information Form



Date Completed: _____

NAME:

First

Middle Initial

Last

Date of Birth

MEDICAL CONDITIONS:

Diabetes

Asthma

High Blood Pressure

Heart Disease

COPD

Alzheimer's Disease/ Dementia

Heart Failure

Arthritis

Other (please specify)

Stroke

Cancer

ALLERGIES (Food, medication and/or environmental)

SURGERIES AND DATES:

Surgery:

Date:

Surgery:

Date:

PHYSICIANS:

Name:

Specialty:

Address:

Phone:

HOSPITAL PREFERENCE:

HEALTH INSURANCE COMPANY:

PETS:

Please contact _____ at _____ to care for my pet, _____.

Name

Phone #

Pet's Name

A community benefit sponsored by:



Sun Health™ and



Banner Health®

EMERGENCY CONTACTS:

Name:	Relationship:	Home Phone:	Work Phone:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS:

Name:	Dosage/Strength:	Quantity:	Purpose/Special Instructions:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ADVANCE DIRECTIVES/LIVING WILL:

Do you have an Advance Directive/Living Will? YES NO

❖ Consider filing a scanned copy of your advance directive/living will on the File of Life flash drive.

Additional forms available at SunHealthWellness.org/VialofLife or by calling (623) 832-9355