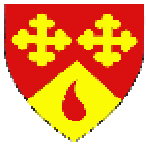
Warwick



Member Medical History Form

This form is intended to gather medical history information from members of *Warwick* to aid emergency medical personnel if you get injured or ill and cannot speak. This information is confidential and cannot be shared with anyone without your written permission. No one else may have access to this information by Federal HIPAA regulation.

Mundane Name:_____
Persona Name:_____
Address:_____
City:_____**State:**_____**Zip Code:**_____
Home Phone:_____**Alternate Phone:**_____
Person to be contacted in case of an Emergency (name,phone number,relationship):
_____
Primary Care Physician (name and phone number):_____
_____
Allergies:_____
_____
Medications (include name and dosage):_____
_____
Past Medical History:

Medical Condition	Yes	No	Medical Condition	Yes	No
Asthma			Heart Cath/Stent		
Bleeding Disorder			Hypertension		
Clotting Disorder			Open Heart Surgery		
Cancer			Pacemaker		
Congestive Heart Failure			Pregnancy		
Chronic Lung Disease			Seizures		
Diabetes			Smoker		
Dentures			Stroke/CVA/TIA		
Emphysema			Surgery		
Glasses/contacts			Thyroid Disease		
Heart Disease			Other:		

Additional information (especially if answered yes to any of the above questions or Have had surgery in the last 6 months:_____
_____

I, the undersigned, understand that I am voluntarily giving this information and may ask for it back at any time. I agree that I will update this form in the event that a condition changes or occurs. My information may not be shared with others without my written permission. I give permission to use this information by the Hospitaler (Custodian of medical records), and those providing me direct care only.
Signature:_____**Date:**_____
(Parent or legal guardian must sign if the named person is a minor.)