



CHARLOTTE COUNTY RED DOT MEDICAL INFORMATION



Home Address: _____ City: _____ State: FL Zip Code: _____
 Phone: _____ Emergency Key Location: _____ Date Form Completed: _____

Person #1: _____

Name: _____
 Date Of Birth: _____ **Age:** _____
 Sex: M F **Weight:** _____
DNRO: Y N **Living Will:** Y N
 Please include both in pouch
Organ Donor: Y N **Blood Type:** _____
Language: _____
Hospital of Preference: _____
Doctor: _____ **Phone #:** _____

Person #2: _____

Name: _____
 Date Of Birth: _____ **Age:** _____
 Sex: M F **Weight:** _____
DNRO: Y N **Living Will:** Y N
 Please include both in pouch
Organ Donor: Y N **Blood Type:** _____
Language: _____
Hospital of Preference: _____
Doctor: _____ **Phone #:** _____

Medical History (Please circle)

Cardiac: Y N **Type:** _____
Pacemaker: Y N **AICD:** Y N
Respiratory problems: Y N **Type:** _____
Stroke: Y N **Deficit:** _____
Immobility: Walker Wheelchair Cane Bed bound
Blood Pressure Problems: Y N HIGH LOW
Anemia: Y N
Cancer: Y N **Type:** _____
Diabetic: Y N **Insulin Dependant?** Y N
Epilepsy / Seizures: Y N
Dementia / Alzheimer's: Y N
Kidney Dialysis: Y N **HEPATITIS:** Y N
AIDS: Y N **HIV:** Y N **TB:** Y N
Vision Impaired: Y N **Blind:** R L **Glaucoma:** Y N
Glasses: Y N **Contact Lenses:** Y N
Hearing Impaired: Y N **Deaf:** L R **Hearing Aid:** Y N
Dentures: Y N Upper Lower Both
Past Significant Injuries: _____
Past Surgeries: _____

Medical History (Please circle)

Cardiac: Y N **Type:** _____
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Past Significant Injuries: _____
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MEDICATIONS & Supplements

Name of Medication	Dosage	Times per Day

Allergies: _____

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Allergies: _____

HOSPITAL INFORMATION

In the event your living will is not available the intent of the advanced directives follows:

Ventilator	Yes	No	Tube Feeding	Yes	No
Kidney Dialysis	Yes	No	Hospice Care	Yes	No
Pain Medication	Yes	No			

Signature _____ **Date** _____
Witness _____ **Date** _____

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Signature _____ **Date** _____
Witness _____ **Date** _____

Emergency Contact information:

Name: _____ Address: _____ Relationship: _____
 Telephone #s: Home: _____ Cell phone: _____ Work: _____