SaintFrancis Health System

PATIENT INFORMATION CARD 9251-6202 / 10-97

DATE

Place this card in your wallet.
If you have an advance directive please bring a copy with you to the hospital.

PATIENT - NAME in FULL

PRIMARY PHYSICIAN

REFERRING PHYSICIAN

ALLERGIES

TO MEDICATION - FOOD - ENVIRONMENTAL FACTORS - LATEX

NAME	DESCRIBE REACTION

Height: **Weight:** DATE

MEDICATIONS

INCLUDE PRESCRIPTION AND OVER-THE-COUNTER

NAME	DOSE	HOW OFTEN?

- OVER

PATIENT INFORMATION CARD

9251-6202 / 10-97 - *SIDE 2*

IMMUNIZATION HISTORY

PLEASE GIVE DATE FOR EACH IMMUNIZATION

DATE

- ☐ Flu .....
- ☐ Hepatitis B .....
- ☐ Measles .....
- ☐ Pneumonia .....
- ☐ Rubella .....
- ☐ TB Skin Test .....
- ☐ Tetanus .....

MEDICAL HISTORY

(Check All Applicable)

☐ None	☐ Lung Disease
☐ Arthritis	☐ Kidney Disease
☐ Bleeding	☐ Pacemaker
☐ Cancer	☐ Phlebitis
☐ Cataracts	☐ Now Pregnant
☐ Diabetes	☐ Seizures
☐ Drug/Alcohol Use	☐ Sleep Apnea
☐ Fractures	☐ Stomach/Bowel
☐ Glaucoma	☐ Stroke
☐ Heart Disease	☐ Tobacco Use
☐ High Blood Pressure	☐ Ulcer
☐ Infectious Disease	☐ Yellow Jaundice

☐ Blood Transfusion - *Date* .....

☐ Other - *Specify* .....

OTHER: