MEDICAL INFORMATION *(Continued)*

What medical problems do you have (check all that apply)

☐ Allergies ☐ Alzheimers/Dementia ☐ Arthritis ☐ Asthma

☐ Cancer ☐ Cholesterol ☐ Diabetes ☐ Eye/Vision

☐ Heart ☐ High Blood Pressure ☐ Mental Health ☐ Stroke

☐ Other: ______________________________

Past Surgeries (type and date) ______________________________

____

____

____

Blood Type: ______________________________

Do you: Wear dentures? ☐ Yes ☐ No Wear glasses? ☐ Yes ☐ No

Wear contacts? ☐ Yes ☐ No Use oxygen? ☐ Yes ☐ No

CURRENT MEDICATIONS *(Include over-the-counter medications)*

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Name ______________ Dosage ______________ Times ______________

Where do you keep your medications? ______________________________