SEVEN HILLS VITAL RECORDS for_____
updated on _____/_____/_____by_____

PLEASE USE A PENCIL TO COMPLETE THIS FORM
Remember to update this form whenever there is a change in information

Name_____ Home phone ( )_____-_____ Male O Female O
Address_____ City_____ State_____ Zip_____
Date of Birth:_____/_____/_____ Place of Birth:_____
People living at this address: _____adults_____ children Pets: How many? _____Cat ____Dog
I speak_____/ understand_____/read_____ English. Other languages spoken:_____
Education level: Elementary_____ High School_____ College_____ Occupation_____

MEDICAL HISTORY

Condition treated for:
O Anemia O Cancer O Stroke O Blood Pressure O Memory loss O Asthma
O Head injury O Swallowing problems O Heart condition O Other_____

Pacemaker O yes O no Implanted defibrillator O yes O no
Diabetic O yes O no Insulin dependent O yes O no
Dialysis O yes O no If yes, location_____
Normal blood pressure _____/_____ Last Tetanus shot _____/_____ Medic alert tag O yes O no
Major Illnesses_____ Surgeries_____
_____ _____
_____ _____
_____ _____

MEDICATIONS

NOTE: Keep ALL prescriptions in one place so emergency responders can locate them quickly.
Location of medications (prescription and non-prescription)_____
Location of supplements, vitamins etc._____
Pharmacy is_____ Phone ( )_____-_____
The person who knows my current prescription information
Name_____ Relationship_____ Phone ( )_____-_____

ALLERGY INFORMATION

I have the following allergies:
Medications_____ Latex O yes O no
Insect bites_____ Epi Pen O yes O no
Foods_____ Pollen_____ Chemicals_____
Other_____

ADDITIONAL IMPORTANT INFORMATION

Medicare #_____
Medicaid #_____
Private Insurance provider
_____
Policy #_____
Guardianship O yes O no
Guardian's name_____
_____
Phone ( )_____-_____
Agencies involved in my care
_____
_____

Living Will O yes O no
Durable Power of Attorney for Health Care O yes O no
Name_____ Phone ( )_____-_____
DNR (Do Not Resuscitate) O yes O no
If yes, DNR for O Arrest O Comfort Care
Location of DNR_____
Religious affiliation_____
Please contact_____
Special instructions in case of an emergency
_____
_____
_____

EMERGENCY CONTACTS

NAME	CITY/STATE	RELATIONSHIP	PHONE
_____	_____	_____	( )_____-_____
_____	_____	_____	( )_____-_____
_____	_____	_____	( )_____-_____

MY MEDICAL PROVIDERS

	Primary	Other	Other
Physician	_____	_____	_____
Medical Specialty	_____	_____	_____
City	_____	_____	_____
Telephone	_____	_____	_____
Hospital Choice	O Parma General	O Marymount	O Kaiser Parma

The following information will enable better communication in the case of an emergency. Please check all the areas that best describe your present situation.

AMBULATION – WALKING AID

_____I walk with a cane
_____I use a walker
_____I need someone to walk with me
_____I use a wheelchair
_____I am unable to walk

VISION

_____I need large print
_____I wear glasses/contact lenses
_____I need glasses/contact lenses for reading
_____Glaucoma
_____Macular degeneration
_____Cataracts
_____I neglect objects __right side __left side
_____Legally blind
_____Need bright light
_____Glare and lights are bothersome

HEARING

_____I have a severe hearing loss
_____I am able to read lips
_____I understand and use sign language
_____I wear hearing aids ____right ____left
_____Please write out the information
_____Gestures are helpful
_____I am sensitive to loud noises

COMPREHENSION

_____I have trouble understanding sentences that are spoken to me
_____I have trouble remembering things spoken to me
_____I have trouble reading sentences
_____I have trouble following complex directions
_____Too much information at one time confuses me
_____Too much background noise makes it harder to understand/concentrate

SPEECH

_____My speech is difficult to understand
_____My speech is impaired from stroke
_____I have a communication chart
_____I have a communication devise
_____Ask me yes or no questions
_____I have trouble saying the correct word
_____I sometimes say the incorrect word
_____I have trouble explaining/describing details
_____Writing out the information is helpful

MEMORY

_____Speak slower
_____Use short sentences
_____Please write out the information
_____I need one step directions
_____I have trouble thinking of words
_____I have trouble explaining more complex thoughts
_____Gestures are helpful
_____Give me two word choices
_____Ask me yes or no questions
_____When there is too much stimulation I get upset or agitated
_____Sometimes I get confused

FOR ADDITIONAL FORMS AND INFORMATION CONTACT CITY HALL @ (216) 524-4421 OR DOWNLOAD FORMS @ WWW.SEVEN HILLSOHIO.ORG

I am enrolled in the **Safe Return Program** - Please call: 1-800-572-1122
24 hours a day to file a report I have a history of wandering O yes O no
Places where I may have wandered to:
_____
_____
I am a care giver for _____who cannot be left alone. In case of emergency contact
Name_____
Address_____
Phone_____

In signing this I agree that any information as reported on my **VITAL RECORDS** may be used by emergency responders (Police/Fire/EMS) and conveyed to hospital emergency department staff in order to better respond to my health emergency.

Signature:_____