

**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 <input type="checkbox"/> Female <input type="checkbox"/>
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:			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Blood Pressure
<input type="checkbox"/> Head injury	<input type="checkbox"/> Swallowing problems	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Other _____
Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no	Implanted defibrillator <input type="checkbox"/> yes <input type="checkbox"/> no		
Diabetic <input type="checkbox"/> yes <input type="checkbox"/> no	Insulin dependent <input type="checkbox"/> yes <input type="checkbox"/> no		
Dialysis <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, location _____		
Normal blood pressure ____/____	Last Tetanus shot ____/____	Medic alert tag <input type="checkbox"/> yes <input type="checkbox"/> 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 <input type="checkbox"/> yes <input type="checkbox"/> no		
Insect bites _____	Epi Pen <input type="checkbox"/> yes <input type="checkbox"/> no		
Foods _____	Pollen _____	Chemicals _____	
Other _____			

**ADDITIONAL IMPORTANT INFORMATION**

Medicare # _____	Living Will <input type="checkbox"/> yes <input type="checkbox"/> no
Medicaid # _____	Durable Power of Attorney for Health Care <input type="checkbox"/> yes <input type="checkbox"/> no
Private Insurance provider _____	Name _____ Phone ( ) _____ - _____
Policy # _____	DNR (Do Not Resuscitate) <input type="checkbox"/> yes <input type="checkbox"/> no
Guardianship <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, DNR for <input type="checkbox"/> Arrest <input type="checkbox"/> Comfort Care
Guardian's name _____	Location of DNR _____
_____	Religious affiliation _____
_____	Please contact _____
Phone ( ) _____ - _____	Special instructions in case of an emergency _____
Agencies involved in my care _____	_____
_____	_____

**EMERGENCY CONTACTS**

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

**MY MEDICAL PROVIDERS**

	Primary	Other	Other
Physician	_____	_____	_____
Medical Specialty	_____	_____	_____
City	_____	_____	_____
Telephone	_____	_____	_____
Hospital Choice	<input type="radio"/> Parma General <input type="radio"/> Marymount <input type="radio"/> 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**

<p>I am enrolled in the <b>Safe Return Program</b> - Please call: 1-800-572-1122          24 hours a day to file a report                    I have a history of wandering                    <input type="radio"/> yes    <input type="radio"/> no          Places where I may have wandered to:          _____          _____</p> <p>I am a care giver for _____ who cannot be left alone. In case of emergency contact          Name _____          Address _____          Phone _____</p>
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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: \_\_\_\_\_