Personal Medical Information

Citizens' Association of Palm Beach

Palm Beach Civic Association

To complete the form electronically go to www.citizensassociationofpalmbeach.org/fol

Date: _____

Name: _____

Address: _____

Phone #: _____

Sex: M ☐ F ☐ Date of Birth: ___/___/___

Emergency Contacts: Doctors

Primary: _____

Address: _____

Phone #: _____

2nd Dr.: _____

Address: _____

Phone #: _____

Dentist: _____

Address: _____

Phone #: _____

Emergency Contacts: Personal

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

Special Instructions for Emergency Contacts:

_____

_____

Medical Insurance

Primary Insurance: _____

Policy #: _____

Secondary Insurance: _____

Policy #: _____

Medical History

Heart Disease	☐	Stroke	☐
Breathing Problems	☐	High Blood Pressure	☐
Kidney Disease	☐	Abdominal Problems	☐
Diabetes	☐	Cancer	☐

OTHER: _____

_____

_____

Allergies: _____

_____

Vaccine				Date/s
COVID-19	No ☐	Yes ☐		
Booster #1	No ☐	Yes ☐		
Booster #2	No ☐	Yes ☐		
Booster #3	No ☐	Yes ☐		
Flu	No ☐	Yes ☐		
Pneumonia	No ☐	Yes ☐		
Shingles	No ☐	Yes ☐		
Tetanus	No ☐	Yes ☐		

Medication	Dosage	Frequency

Recent Surgery, Implants, Pacemaker Cochlear &/or Dental Implants or Stents — Date

Religion: _____

Have You Signed Any Of The Following?				Where Is It Located?
Living Will	No ☐	Yes ☐		
Health Care Proxy	No ☐	Yes ☐		
EMS-NO CPR or DNR form	No ☐	Yes ☐		