SMEAD®

HEALTH

I HAVE HAD TREATMENT FOR:

Name: _____

❑ Cancer:
❑ Tuberculosis:
❑ Kidney disorder:
❑ Diabetes:
❑ Circulatory problems:
❑ Heart:
❑ Arthritis:
❑ Dementia:
❑ Other: _____

_____

_____

I AM ALLERGIC TO THE FOLLOWING DRUGS:

1. _____
2. _____
3. _____
4. _____

PHYSICIAN:

Physician: _____ Phone: _____
Address/Name of clinic: _____
Treats me for: _____

Physician: _____ Phone: _____
Address/Name of clinic: _____
Treats me for: _____

Physician: _____ Phone: _____
Address/Name of clinic: _____
Treats me for: _____

I have a living will: ❑ Yes ❑ No
Location of document: _____
Additional remarks: _____

Do not resuscitate instruction: ❑ Yes ❑ No
Location of document: _____
Additional remarks: _____

I am an organ donor: ❑ Yes ❑ No
Additional remarks: _____