



# Rapid Assistance to Community Emergencies, Inc.

P.O. Box 334, Delaware, Ohio 43015

## MEDICAL DATA

Member Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_ SEX:  M  F

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_-\_\_\_\_

Specialist Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_-\_\_\_\_ Specialty: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_-\_\_\_\_

ALLERGIES (Medication & Environmental): \_\_\_\_\_

PAST MEDICAL HISTORY: (Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS, ARC or HIV                      | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Lou Gahrig's Disease           |
| <input type="checkbox"/> Aneurysm                              | <input type="checkbox"/> Coronary Insufficiency  | <input type="checkbox"/> Major Organ Failure/Transplant |
| <input type="checkbox"/> Angina                                | <input type="checkbox"/> Depression              | <input type="checkbox"/> Meningitis                     |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Mental Health Disorders        |
| <input type="checkbox"/> Atxia                                 | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Migraines                      |
| <input type="checkbox"/> Back Strains                          | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Motor/Sensory Aphasia          |
| <input type="checkbox"/> Bursitis                              | <input type="checkbox"/> Graves Disease          | <input type="checkbox"/> Multiple Sclerosis             |
| <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Guillian Barr Syndrom   | <input type="checkbox"/> Pacemaker Implantation         |
| <input type="checkbox"/> Cardiomyopathy                        | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Parkinson's Disease            |
| <input type="checkbox"/> Carotid Artery Disease                | <input type="checkbox"/> Heart Bypass Surgery    | <input type="checkbox"/> Peripheral Vascular Disease    |
| <input type="checkbox"/> Chemical Dependency                   | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Phlebitis                      |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Prostate Disorders             |
| <input type="checkbox"/> Congenital Disorders                  | <input type="checkbox"/> Hyperthyoidism          | <input type="checkbox"/> Renal Failure                  |
| <input type="checkbox"/> Congestive Heart Failure              | <input type="checkbox"/> Hysterectomy            | <input type="checkbox"/> Spinal Disorders               |
| <input type="checkbox"/> OTHER(s): _____                       | <input type="checkbox"/> Kidney Failure          | <input type="checkbox"/> Stroke/CVA/TIA                 |

Health Insurance Carrier Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Health Insurance Claim Telephone Number: (\_\_\_\_) \_\_\_-\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

CONTACT HOME NUMBER: (\_\_\_\_) \_\_\_-\_\_\_\_ CONTACT WORK NUMBER: (\_\_\_\_) \_\_\_-\_\_\_\_