

# GOLDEN CARE

## MEMBERS MEDICAL DATA

Please follow the accompanying directions carefully and be sure to use black ink (black roller tip pen is best). All forms MUST be dated and signed.

**PLEASE PRINT!**

First Name	MI	Last Name

Number Street (+ Apt/Unit No., if applicable)

City

State  Zip Code + 4, if known

(Area Code) - Telephone Number

Home  -  -

Work  -  -

Cell  -  -

<p style="text-align: center;"><b>Hair Color</b></p> <p><input type="radio"/> Black   <input type="radio"/> Blond   <input type="radio"/> Red  <input type="radio"/> Brown   <input type="radio"/> Gray   <input type="radio"/> Bald</p>	<p style="text-align: center;"><b>Gender</b></p> <p><input type="radio"/> Female  <input type="radio"/> Male</p>	<p style="text-align: center;"><b>Marital Status</b></p> <p><input type="radio"/> Married  <input type="radio"/> Separated  <input type="radio"/> Divorced  <input type="radio"/> Widowed  <input type="radio"/> Never Married</p>	<p style="text-align: center;"><b>Physical Aids</b></p> <p><input type="radio"/> Brace   <input type="radio"/> Contacts  <input type="radio"/> Dentures   <input type="radio"/> Hearing Aid  <input type="radio"/> Walker   <input type="radio"/> Cane  <input type="radio"/> Glasses   <input type="radio"/> Wheelchair</p>	<p style="text-align: center;"><b>Blood Type</b></p> <p><input type="radio"/> A   <input type="radio"/> B  <input type="radio"/> AB   <input type="radio"/> O  <input type="radio"/> NEG   <input type="radio"/> POS</p>
<p style="text-align: center;"><b>Eye Color</b></p> <p><input type="radio"/> Blue   <input type="radio"/> Brown  <input type="radio"/> Green   <input type="radio"/> Hazel</p>	<p style="text-align: center;"><b>Retired?</b></p> <p><input type="radio"/> Yes  <input type="radio"/> No</p>	<p>Height (ft.-in.) <span style="border: 1px solid black; display: inline-block; width: 100px; height: 24px;"></span> Weight (lbs.) <span style="border: 1px solid black; display: inline-block; width: 100px; height: 24px;"></span></p>		

Date of Birth (mm/dd/yyyy)	Social Security Number	Employer, if applicable

1. Personal Physician/Family Doctor (First Initial and Last Name)	Physician Telephone Number

2. Personal Physician/Family Doctor (First Initial and Last Name)	Physician Telephone Number

Medicare Number, if applicable	Health Insurance Name	Policy Number

Emergency Contact Name	Telephone Number	Relationship of Contact

Please turn over and continue filling out the back of this form.....

**MEDICAL DATA: Fill in the circles for all current and past medical conditions.....**

<input type="radio"/> Aids/HIV+	<input type="radio"/> Alcoholism	<input type="radio"/> Alzheimer's	<input type="radio"/> Anemia	<input type="radio"/> Angina
<input type="radio"/> Anxiety	<input type="radio"/> Arthritis	<input type="radio"/> Asthma	<input type="radio"/> Back Trouble	<input type="radio"/> Blind
<input type="radio"/> Blood Disorder	<input type="radio"/> Bronchitis	<input type="radio"/> Cancer	<input type="radio"/> Cataracts	<input type="radio"/> Circulatory Problems
<input type="radio"/> Congest. Heart Failure	<input type="radio"/> Emphysema	<input type="radio"/> Depression	<input type="radio"/> Diabetes	<input type="radio"/> Digestive Problems
<input type="radio"/> Drug Misuse	<input type="radio"/> Deaf	<input type="radio"/> Epilepsy	<input type="radio"/> Equilibrium	<input type="radio"/> Freq. Headaches
<input type="radio"/> Glaucoma	<input type="radio"/> Gout	<input type="radio"/> Hay Fever	<input type="radio"/> Hernia	<input type="radio"/> Heart Attack
<input type="radio"/> Heart Condition	<input type="radio"/> Head Injury	<input type="radio"/> Hepatitis	<input type="radio"/> High Blood Pressure	<input type="radio"/> Incontinence
<input type="radio"/> Irregular Heartbeat	<input type="radio"/> Liver Disease	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Low Blood Sugar	<input type="radio"/> Multiple Sclerosis
<input type="radio"/> Mute	<input type="radio"/> Osteoporosis	<input type="radio"/> Paralysis	<input type="radio"/> Parkinson's Disease	<input type="radio"/> Phlebitis
<input type="radio"/> Pneumonia	<input type="radio"/> Polio	<input type="radio"/> Poor Nutrition	<input type="radio"/> Prostate Problems	<input type="radio"/> Renal/Kidney Prob.
<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Shingles	<input type="radio"/> Sinus Problems	<input type="radio"/> Stroke	<input type="radio"/> Thyroid Disease
<input type="radio"/> Tuberculosis	<input type="radio"/> Ulcer			
<input type="radio"/> Other Medical conditions (Write In)				

**Allergies: Fill in the circles for any listed allergies; if needed, write in other allergies..**

<input type="radio"/> Anesthetics	<input type="radio"/> Antibiotics	<input type="radio"/> Aspirin	<input type="radio"/> Codeine	<input type="radio"/> Cortisone
<input type="radio"/> Demerol	<input type="radio"/> Iodine	<input type="radio"/> Morphine	<input type="radio"/> Novacaine	<input type="radio"/> Penicillin
<input type="radio"/> Sulfa	<input type="radio"/> Tetanus Toxoid	<input type="radio"/> Tetracycline	<input type="radio"/> Insect Stings	<input type="radio"/> IVP Dye
<input type="radio"/> No Known Allergies	<input type="radio"/> Food			
<input type="radio"/> Other Allergies (Write In)				

**Medications: Please print neatly a list of all medications your are currently taking**

Name of Medication	Dosage	Name of Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Surgeries: Fill in the circles for prior surgeries...**

<input type="radio"/> Appendectomy	<input type="radio"/> Cataract	<input type="radio"/> Carotid Artery	<input type="radio"/> Gall Bladder	<input type="radio"/> Heart Bypass
<input type="radio"/> Heart Valve	<input type="radio"/> Hip Repair/Replacement	<input type="radio"/> Hysterectomy	<input type="radio"/> Pacemaker	<input type="radio"/> Prostate
<input type="radio"/> Other Surgeries (Write In)				

**ORGAN DONOR AUTHORIZATION (optional)**

Upon my death I wish to donate:

- Any needed organs or parts
- My body for anatomical study if needed
- Only the following organs or parts

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

**Do you have a....**

Living Will?  Yes  No

Durable Power of Attorney or Health Care?  Yes  No

**If so, fill in location of documents....**

Is this application your...  First  Update

If updating, old ID File #:

Please check box if you are submitting additional pages of information