Medical Form	
Name	
Female/Male	
DOB	
Address	
Emergency Contact One	
Emergency Contact Two	
Emergency Contact Three	Angels Service LLC 720-256-8875x2
Last four Social	
Primary / Special Diagnose	
Allergies	
Special Notes, Remarks, Conditions	
Insurance One	
Insurance Two	
Preferred Doctor	
Preferred Dentist	
Preferred Hospital	
Recent Procedures / History	
Religion	
Advanced Directives	

Health Care Proxy	First: Name _____Relationship _____Phone _____ **Name authorizing Angels Service LLC as secondary Health Care Proxy if the first listed above is not available** Name_____ Signature_____
	Personal History and Family History

	Self	Family		Self	Family		Self	Family
NO KNOWN CONDITIONS			Abnormal ekg			Adrenal Insufficiency		
Angina			Asthma			Bleeding Disorder		
Cancer (details)			Cardia Dysthymia			Cataracts		
Clotting Disorder			Coronary Bypass Graft			Dementia (details) _____		
Diabetes/Insulin Dependent			Eye Surgery			Glaucoma		
Hearing Impaired			Heart Valve Prosthesis			Hemodialysis		
Hemolytic Anemia			Hepatitis (details) _____			Hypertension		
Hypoglycemia			Leukemia			Lymphomas		
Memory/Cognitive Impaired			Myasthenia Gravis			Pacemaker		
Renal Failure			Seizure Disorder			Sickle Cell Anemia		
Stroke			Tuberculosis			Vision Impaired		
Other								

Any other notes needed for doctors appts	

Additional Family Medical History:

Describe the type of assistance needed for medication. Please Highlight the options that apply. More than one can be highlighted.

Completely Independent, understands everything, no assistance needed	Capable of taking them but may choose not to at times.
Understand the medications	Understands the medication but needs a person to remind them.
Someone fills a med box reminder and client take medication	Can be resistive to medication, detailed support plan needed.
Understands the medication but needs technology reminders to take them.	Needs medication but refuses to take it. Health needs extra monitoring with Doctor and Case Manager.

Notes of Assistance:

Are any of the below medications anti-depressants, anti-anxiety, or another type of psychotropic medication? **Yes or No**

Medication Name	Dose	Type (Pill, Liquid, Etc.)	Taken How Many Times of Day	Taken At What Time	Taken for What Reason, Include what diagnosis	How is it taken (with water, in food, etc.)	Any Adverse Effect We Should Look Out For	Who Prescribed This Medication	Is This OTC or RX

Physician's Name _____ Physician's Phone _____ Physician's Fax _____

Physician's Signature _____ Date of Signature _____