# Medical Info

Family name: ______________________________________________

My name/s: ______________________________________________

Nickname: ______________________________________________

Medical Aid: ______________________________________________

Tel number: ______________________________________________

E-mail: ______________________________________________

Medical Plan: ______________________________________________

Member number: ______________________________________________

Main member: ______________________________________________

My blood group: ☐☐

Dependent/s:

1. ______________________________________________

Blood group: ☐☐

2. ______________________________________________

Blood group: ☐☐

3. ______________________________________________

Blood group: ☐☐

4. ______________________________________________

Blood group: ☐☐

Clutter Bug

I have the following conditions: *(e.g. Hypertension)*

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________
4. ______________________________________________
5. ______________________________________________
6. ______________________________________________
7. ______________________________________________
8. ______________________________________________

My chronic medication

1. ___
2. ___
3. ___
4. ___
5. ___
6. ___
7. ___
8. ___

Allergies

1. ___
2. ___
3. ___
4. ___
5. ___

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I have had the following illnesses e.g. *(measles)*

1. ___
2. ___
3. ___
4. ___
5. ___
6. ___
7. ___
8. ___

Surgery (including Cosmetic, transplants, implants, prosthetic/s etc.)

1. ___
2. ___
3. ___
4. ___
5. ___
6. ___
7. ___