



Saint Francis Hospital  
Saint Francis Hospital South  
Saint Francis Hospital Vinita  
Saint Francis Hospital Muskogee

## HEALTH INFORMATION CARD

10030207 front / 03-17

DATE

**Place this card in your wallet.**  
**If you have an advance directive please**  
**bring a copy with you to the hospital.**

PATIENT - NAME IN FULL

PHYSICIAN(S)

### ALLERGIES

TO MEDICATION - FOOD - ENVIRONMENTAL FACTORS - LATEX

NAME	DESCRIBE REACTION

### IMMUNIZATION HISTORY

PLEASE GIVE DATE FOR EACH IMMUNIZATION

DATE

- ☐ Flu Vaccine -----
- ☐ Pneumonia Vaccine -----
- ☐ Tetanus -----

### MEDICAL HISTORY - CHECK ALL APPLICABLE

- |   |   |
|---|---|
| <input type="checkbox"/> None                           | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Pacemaker/ICD    |
| <input type="checkbox"/> Bleeding                       | <input type="checkbox"/> Phlebitis        |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Now Pregnant     |
| <input type="checkbox"/> Cataracts                      | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Sleep Apnea      |
| <input type="checkbox"/> Drug/Alcohol Use               | <input type="checkbox"/> Stomach/Bowel    |
| <input type="checkbox"/> Fractures                      | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Tobacco Use      |
| <input type="checkbox"/> Heart Disease/Heart Attack     | <input type="checkbox"/> Ulcer            |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Yellow Jaundice  |
| <input type="checkbox"/> Infectious Disease             | <input type="checkbox"/> Implants         |
| <input type="checkbox"/> Lung Disease                   | <input type="checkbox"/> Medication Pumps |
| <input type="checkbox"/> Blood Transfusion - DATE _____ | <input type="checkbox"/> IV Catheter      |
| <input type="checkbox"/> Other - SPECIFY _____          |   |

**Attention Smokers: In the interest of your health,**  
**we recommend that you quit smoking.**

- OVER



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## 10030207 back / 03-17

INCLUDE PRESCRIPTION AND OVER-THE-COUNTER,  
HERBALS, VITAMINS, ETC.



10030207 back / 03-17

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