Florilow Oaks RV Park Medical
Patient & Pet Information

This information is for the ambulance paramedics to be delivered to the hospital up your arrival. One form per person and please print legibly and update as needed. When completed, fold and place inside the **RED Envelope** and attach this to your ***REFRIGERATOR*** (The RED Envelope attached to any other place in your home turns your vital medical information into a treasure hunt and possibly overlooked.)

Patient Information:

Name (First, Middle, Last):_____ Date: _____

All this infomation here is for living at Florilow Oaks RV Park:

Address: 4272 South US 301, LOT _____ Bushnell _____ Florida _____ 33513-3602
Street City State Zip Code

Phone (Home):_____ (Work): _____ (Cell):_____

Social Security Number: _____ DOB (dd-mmm-yyyy): _____ Sex: ☐ M ☐ F

Email: _____ Alternate Email:_____

Insurance Information:

Primary Insurance: _____

Policy #: _____

Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Patient Relationship to Policy Holder: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Patient Relationship to Policy Holder: _____

Florilow Oaks RV Park Medical
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Physician Information:

Physician Information:

Physician: _____ Phone: _____

Medical Center: _____ Email: _____

Address: _____ City: _____ State: _____

Physician Information:

Physician: _____ Phone: _____

Medical Center: _____ Email: _____

Address: _____ City: _____ State: _____

Emergency Contacts:

Emergency Contact:

Name: _____

Phone (Home): _____ (Cell): _____

Relationship to Patient: _____ Email: _____

Alternate Emergency Contact:

Name: _____

Phone (Home): _____ (Cell): _____

Relationship to Patient: _____ Email: _____

Additional Information:

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Reset Buttons

MEDICAL HISTORY

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

Comments:

Allergies:

Medications:

Medical History (including surgeries)

Do you smoke? ☐Yes ☐No If yes, how much?_____

Do you drink alcohol? ☐Never ☐Occasionally ☐Every week ☐Everyday

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Pet Information:

PEOPLE INFORMATION

Who will take care of my pet: _____

Veterinarian Information

Veterinarian Center: _____

Name: _____

Address: _____

Email: _____

Phone: _____

PET INFORMATION

Pet's Name: _____

☐ M ☐ F Age: _____ DOB: _____

Spayed/Neutered ☐ Yes ☐ No

ID Microchip ☐ Yes ☐ No

Species (dog, cat, etc.): _____

Breed:

Color, markings, unique, features: _____

_____

Other identifiers (collar, etc.): _____

_____

Diet and feeding info: _____

_____

_____

Medical info (with medicine dosage/instructions): _____

_____

_____

Personality/behavior info: _____

_____

_____

RECOMMENDED ATTACHMENTS

- ☐ Proof of vaccinations
- ☐ Important medical records/prescriptions
- ☐ Photos of your pet
- ☐ Animal license information
- ☐ Pet medical insurance

Florilow Oaks RV Park Medical
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Medical Patient Information

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