

Personal Fact Sheet

Please keep this completed form ready for an emergency, along with copies of your insurance card, Medicare/Medicaid card, Power of Attorney, Living Will or POLST, and organ donor affidavit (if applicable).

Personal Information

Full Legal Name: _____ Gender: Male Female

Preferred Name: _____ Date of Birth: ____/____/____

Address: _____ City/State/Zip: _____

Current Weight: _____ Height: _____ Preferred Faith Tradition: _____

Primary Language: _____ Check all that apply: Eye Glasses Contact Lenses Dentures Hearing Aid

Other Communication issues: _____
(i.e. Easily confused, speech or hearing impairment, etc.)

Medical Information

Allergies or Adverse Reactions to Medications: _____

Food Allergies or Sensitivities: _____

Other Dietary Needs: _____
(i.e. low sodium, diabetic, halal, kosher, vegetarian, etc.)

Existing Conditions or Hospitalizations in last 5 years: _____

Prescription Name	Dosage	# Times per Day

This form is provided courtesy of



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Protecting What Matters

455 Dunham Road, Suite 200, St. Charles, IL 60174 ▪ 630.377.3241 ▪ www.StrohscheinLawGroup.com

Emergency Contact Information

	Name	Phone Number	Condition Being Treated
Primary Care Physician			
Specialist #1			
Specialist #2			
Specialist #3			

Caregiver Name: _____

Phone Number: _____

Minister Name: _____

Name of Church: _____

Phone Number: _____

Family Contact Name #1: _____

Relationship: _____ Phone Number: _____

Family Contact Name #2: _____

Relationship: _____ Phone Number: _____

Family Contact Name #3: _____

Relationship: _____ Phone Number: _____

Other Contact Name #: _____

Relationship: _____ Phone Number: _____

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