



**Most Recent Vaccines:**

Tetanus      \_/ \_/ \_

Pneumonia    \_/ \_/ \_

Influenza (Flu)    \_/ \_/ \_



**Medical Conditions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Prior Surgeries or Procedures**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have?**

**Health Care Proxy?**

Yes     No

Name \_\_\_\_\_

Phone \_\_\_\_\_

**Advanced Directive?**

Yes     No

**Non-Hospital DNR**

Yes     No

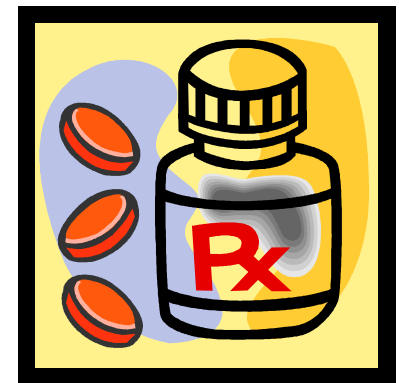
For questions regarding:

- Healthcare proxy*
- Advance Directives*
- Non-Hospital DNR*

or other healthcare choices  
contact your healthcare  
provider.

Visit [www.nyhealth.gov](http://www.nyhealth.gov) for  
more information

**My Medical  
Information**



Courtesy of  
*River Hospital*



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