

Part 2: Confidential Patient Profile

Fill in the appropriate box(es) below for each member of the family that is covered.

| | Member | Spouse | Dependent | Dependent | Dependent |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|
| Last Name <i>(if different from cardholder name)</i> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| First Name | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Middle Initial | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of Birth <i>(mm/dd/yyyy)</i> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Sex <i>(M–Male, F–Female)</i> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Allergies to Medications: Check the appropriate box(es) where allergies to medications exist.

| | | | | | |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Penicillin (31) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine (97) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa (40) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin (4) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other <i>(Please list all)</i> | | | | | |
| None | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Medical History: Check the appropriate box(es) for medical conditions diagnosed by a practitioner.

| | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Diabetes (DIA) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure (HBP) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Condition (HRT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid (THY) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma (EYEGLA) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers (GSTULC) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy (MNM CVSNO) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis (BNECPR) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression (CNSDEP) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis (ART) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Conditions <i>(Please list all)</i> | | | | | |
| None | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If additional space is needed, please attach a separate sheet indicating patient name, date of birth, sex, and appropriate allergies to medications and medical history.

Please list cardholder name and any medications taken regularly, including over-the-counter drugs, or any additional comments you might have.
