Your family's health

You

Your name: ______________________________

Note any health problems, dates diagnosed and course of treatment taken:

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I ☐ do ☐ do not have a living will or other advance medical directives. (For more details about living wills and other advance medical directives, see page 81.)

Name of hospital: ______________________________

Name of primary care physician: ______________________________

Address: ______________________________

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Phone number: ______________________________

Name and address of other health care providers you see: ______________

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List of ongoing prescription medications being taken as of (date): ________

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