LIST ALL MEDICINES YOU ARE CURRENTLY TAKING

Please list prescriptions and over-the-counter medications (ex: aspirin, antacids) and herbals (ex: ginseng, ginkgo).

Make sure you include medications that you are taking routinely and "as needed."

| Name of prescription, Over-the-counter medication, vitamins/supplements & dose | How Often You Take | Reason For Taking |
|--|-----------------------|----------------------|
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Update this form whenever you have a change of medication or medical history.

Keep a copy of this form in your File of Life magnetic packet, which should be placed on your refrigerator. A copy of this form also should be kept in your wallet or purse in case of emergency.

EMERGENCY MEDICAL INFORMATION

| Date Up | odated: |
|--------------------------------------|----------|
| Name: | |
| Address: | |
| Sex: Male / Female Date of Birth | 1: |
| Primary Care Doctor: | |
| Phone #: | |
| Preferred Pharmacy: | |
| Phone #: | |
| Medical Insurance Co.: | |
| Policy #: | |
| Other Medical Insurance: | |
| Policy #: | |
| Medicare / Medicaid: | |
| Policy #: | |
| Living Will: Yes / No | |
| Health Care Power of Attorney: Yes / | No |
| EMERGENCY | CONTACTS |
| Name: | Phone #: |
| Address: | |
| Name: | |
| Address: | |
| MEDICA | L DATA |
| Recent Surgeries/Hospitalizations: | Date: |
| | |
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MEDICAL CONDITIONS

(check all that apply)

| HEART DISEASE | | UNG DISEASE | KIDNEY DISEASE | |
|--------------------------------|---|-----------------------|-----------------------|--|
| CHF/Heart Failure | | COPD/Emphysema | Failure | |
| High Blood Pressure | | Asthma | Insufficiency | |
| Low Blood Pressure | | Fibrosis | Dialysis | |
| High Cholesterol | | Pneumonia | Kidney Stones | |
| Irregular Heart Beat | | Bronchitis | Infections | |
| Pacemaker | | Shortness of Breath | | |
| Heart Attack | | Coughing | | |
| Angina or Chest Pain | | Lung Pain | | |
| Heart Surgery/ ByPass/Stent | | | | |
| | | EUROLOGICAL ISEASE | MALIGNANCY/ CANCER | |
| Bowel Obstruction | | Stroke | Lung | |
| Bleeding | | Bleeding in Brain | Liver | |
| Diverticulitis | | Seizures | Breast | |
| Hiatal Hernia | | Multiple Sclerosis | Stomach | |
| GERD/Reflux | | Parkinson | Leukemia | |
| Diarrhea | | Headaches | Colon | |
| Blood in Stools | | Alzheimers or | Skin | |
| | | Memory Loss | Other: | |
| ENDOCRINE DISEASE | O | THER | | |
| Diabetes | | Arthritis | Vision | |
| Thyroid: | | Back Problem | Problems | |
| High | | HIV | Other | |
| Low | | Sickle Cell | | |
| | | Weight Gain | | |
| | | Weight Loss | | |

ALLERGIES

(check all that apply)

| Aspirin | Laytex | Tetracycline |
|----------------|------------|------------------|
| Barbiturates | Lidocaine | X-Ray Dye |
| Codeine | Morphine | No Known Allergy |
| Demerol | Novocain | Other: |
| Insect Stings | Penicillin | |
| Horse Serum or | Sulfa | |
| Vaccines | | |

Update this form whenever you have a change of medication or medical history.

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UNIVERSAL MEDICATION FORM

(Use pencil on this form to allow for easy changing)

| Date Updated: | | | | | | |
|----------------------------------|------------------------------|--|--|--|--|--|
| Name: | | | | | | |
| Address: | | | | | | |
| Sex: Male / Female Date of Birth | | | | | | |
| Primary Care Doctor: | | | | | | |
| Phone #: | | | | | | |
| Preferred Pharmacy: | | | | | | |
| Phone #: | | | | | | |
| Medical Insurance Co.: | | | | | | |
| | | | | | | |
| Other Medical Insurance: | | | | | | |
| | | | | | | |
| Medicare / Medicaid: | | | | | | |
| | | | | | | |
| MEDICINE ALLERGIES/RI | EACTIONS (describe reaction) | | | | | |
| Drug: | Reaction: | | | | | |
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