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

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 Updated: ____________________

Name: ____________________

Address: ____________________

Sex: Male / Female Date of Birth: ____________________

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: ____________________ Phone #: ____________________

Address: ____________________

MEDICAL DATA

Recent Surgeries/Hospitalizations: ____________________ Date: ____________________

____

____

____

____

(over)

MEDICAL CONDITIONS

(check all that apply)

HEART DISEASE	LUNG 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		
STOMACH DISEASE	**NEUROLOGICAL DISEASE**	**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 Memory Loss	Skin
		Other:
ENDOCRINE DISEASE	**OTHER**	
Diabetes	Arthritis	Vision Problems
Thyroid: ______High ______Low	Back Problem	
	HIV	Other
	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 Vaccines	Sulfa	

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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.: ____________________

Policy #: ____________________

Other Medical Insurance: ____________________

Policy #: ____________________

Medicare / Medicaid: ____________________

Policy #: ____________________

MEDICINE ALLERGIES/REACTIONS (describe reaction)

Drug:	Reaction: