

# 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: \_\_\_\_\_

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# MEDICAL CONDITIONS

(check all that apply)

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

## ALLERGIES

(check all that apply)

<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Laytex	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	Lidocaine	<input type="checkbox"/>	X-Ray Dye
<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	No Known Allergy
<input type="checkbox"/>	Demerol	<input type="checkbox"/>	Novocain	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Insect Stings	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	
<input type="checkbox"/>	Horse Serum or	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	
<input type="checkbox"/>	Vaccines	<input type="checkbox"/>		<input type="checkbox"/>	

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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: \_\_\_\_\_

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