Personal & Medical
Contact Information

Personal Information		
Name		
Address		
Phone		
Date of Birth		
Emergency Contacts	Name	
	Phone	

Medical Information
My medical conditions/allergies are:
Medications I cannot take include:

Optional	
I have an advance directive completed at:	
Location:	
Address:	
Phone:	

Vaccination Record				
Vaccinations	**Mth/ Yr**	**Mth/ Yr**	**Mth/ Yr**	**Mth/ Yr**
Diptheria/Tetanus				
Pneumococcal				
Influenza				
Other				

Medical Contacts		
Primary Care Physician	Name	
	Phone	
Other Physician	Name	
	Phone	
Pharmacist	Name	
	Phone	
Insurance Company	Name	
	Phone	

Over-the-Counter Medicines, Vitamins & Herbal Supplements		
Name	Dosage *(how much)*	Frequency *(how often)*

List all medications prescribed by a physician that you are currently taking.

Medication	Dosage *(how much)*	How often do you take it?	How long have you been taking it?	What is it for?

Don’t forget to list over-the-counter medicines, vitamins, & herbal supplements on back of card.