LIST ALL MEDICINES YOU ARE CURRENTLY TAKING

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

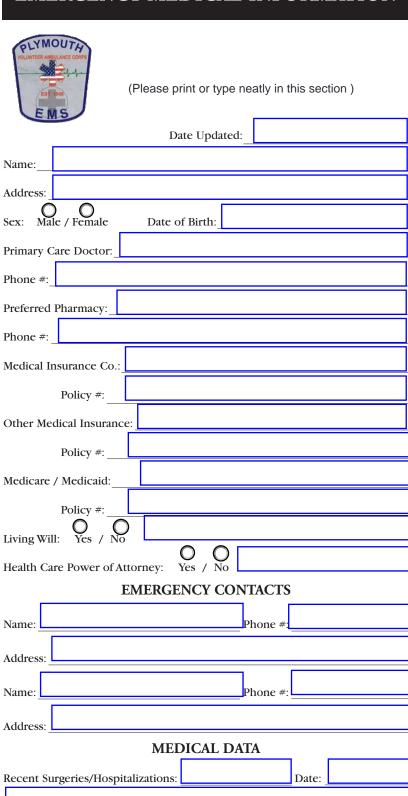
Make sure you include medications that you are taking routinely and "as needed."

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 on your refrigerator. A copy of this form should also be kept in your wallet or purse in case of emergency.

EMERGENCY MEDICAL INFORMATION



1,122	TOTAL DITTAL		
Recent Surgeries/Hospitalizations:		Date:	
			•
			_

(over)

MEDICAL CONDITIONS

(check all that apply)

HEART DISEASE	LUN	IG DISEASE		KIDNEY DISEASE	(Use pencil c	
CHF/Heart Failure	C	OPD/Emphysema		Failure		
High Blood Pressure	A	sthma		Insufficiency		
Low Blood Pressure	Fi	ibrosis		Dialysis	Name:	
High Cholesterol	Pı	neumonia		Kidney Stones	Address:	
Irregular Heart Beat	B	ronchitis		Infections		
Pacemaker	SI	hortness of Breath			Sex: Male / Female	
Heart Attack	С	oughing			Primary Care Doctor:	
Angina or Chest Pain	Lı	ung Pain				
Heart Surgery/ ByPass/Stent					Phone #:Preferred Pharmacy:	
STOMACH DISEASE		JROLOGICAL EASE		MALIGNANCY/ CANCER	Phone #:	
Bowel Obstruction	St	troke		Lung	Medical Insurance Co.:	
Bleeding	B	leeding in Brain		Liver	wiccical histilatice Co	
Diverticulitis	Se	eizures		Breast	Policy #:	
Hiatal Hernia	М	Iultiple Sclerosis		Stomach	Other Medical Insurance:	
GERD/Reflux	Pa	arkinson		Leukemia	Other Medical Histirance.	
Diarrhea	Н	eadaches		Colon	Policy #:	
Blood in Stools	$ \square $ A	lzheimers or		Skin	Medicare / Medicaid:	
	\square	Iemory Loss		Other:	Medicale / Medicald.	
ENDOCRINE DISEASE	OTH	IER			Policy #:	
Diabetes	T A	rthritis		Vision	MEDICINE ALI	
Th <u>yro</u> id:		ack Problem	┢	Problems		
High		IV	\vdash	Other	Drug:	
Low		ickle Cell				
		Veight Gain				
	W W	Veight Loss				
	AL	LERGIES k all that apply)				
Aspirin	AL]	LERGIES		Tetracycline		
Aspirin Barbiturates	AL]	LERGIES k all that apply)		Tetracycline X-Ray Dye		
=	AL] (chec	LERGIES k all that apply) aytex		-		
Barbiturates	AL] (check	LERGIES k all that apply) aytex idocaine		X-Ray Dye		
Barbiturates Codeine	AL] (check	LERGIES k all that apply) aytex idocaine Iorphine		X-Ray Dye No Known Allergy		
Barbiturates Codeine Demerol	ALJ (check	LERGIES k all that apply) aytex idocaine fovocain		X-Ray Dye No Known Allergy		

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

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: