

MED LIST

Information About You

Name _____
 Address _____
 Birth Date _____ Blood Type _____ Weight _____ Height _____
 Pharmacy _____ Phone _____
 Primary Care Physician _____ Phone _____
 Other Physicians _____ Phone _____
 or Specialists _____ Phone _____
 Emergency Contact _____ Phone _____

Questions to Ask My Doctor

Medical Conditions

Asthma Heart Disease Diabetes High Blood Pressure
 Cancer Kidney Disease Other _____

Vaccinations (please note the date of the immunization)

Influenza _____ Pneumococcal _____
 MMR _____ Tetanus/Diphtheria _____

Important Health Care Documents

Health Care Proxy _____
 Location of Document _____
 Health Care Durable Power of Attorney _____
 Interested in Organ or Tissue Donation _____

Health Insurance Plans

Over-the-Counter Medications

Allergy Relief/Antihistamines Diet Pills
 Cough/Cold Medications Herbal/Dietary Supplements
 Aspirin/Other for Pain/Headache/ Fever St. John's Wort
 Antacids Gingko Biloba
 Laxatives Kava Kava
 Sleeping Pills Other (be sure to list on Medication list)

Discontinued Medications/Products (due to Allergies, Side Effects, or Reactions)

Medication/Food/Environment that cause the reaction	Allergy, Side Effects, Reaction or Intolerance Experienced (symptoms, severity)	Date (mm/yy)

