

MEDICINE CARD FOR:

Name: _____

Date of birth: _____

Phone: _____

EMERGENCY CONTACT:

Name: _____

Phone: _____

MY HEALTH CONDITIONS:

- Arthritis
- Diabetes
- Cancer
- Stroke
- Seizures
- Lung problems
- Heart problems
- High blood pressure
- Kidney problems
- Liver problems
- Joint replacement
- Contact lenses
- Dentures/partials
- Lens implant (in my eyes)
- Pacemaker (for my heart)
- Defibrillator (for my heart)
- Hearing aid
- Other: _____

ADVANCE DIRECTIVES I HAVE:

- Living Will
- Durable Power of Attorney for Health Care
- Neither

ALWAYS ASK:

1. What is the name of the medicine and what is it for?
2. How and when do I take it and how long do I take it?
3. Do I need to stay away from any foods, drinks, other medicines or activities while I take this medicine?
4. Are there any side effects and what do I do if they happen?
5. Where can I find out more about this medicine?

Past Surgeries (Operations)	Year
Allergies (Medicine, Food, Latex, other)	Reaction (What happens)

My Doctor and Pharmacy
Doctor's Name: _____ Doctor's Phone Number: _____ Pharmacy Name: _____ _____ Other Doctors: (specialists) _____ _____ _____ _____ _____ _____

Vaccination Dates:

Pneumonia _____
 Flu _____
 Tetanus/diphtheria _____
 MMR _____

