MEDICAL INFORMATION

Keep this record with you at all times

Name _____

Address _____

_____

Phone _____

EMERGENCY CONTACTS

In case of emergency, please contact

Name _____

Phone _____

Doctor _____

Phone _____

Doctor _____

Phone _____

Pharmacy _____

Phone _____

Other _____

Phone _____

CHRONIC CONDITIONS

Indicate any ongoing medical concerns

- ☐ Blood pressure
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart disease
- ☐ Cancer
- ☐ Other

PRESCRIPTION MEDS

Listprescription medications you are currently taking

Med	Dose	Time

OVER THE COUNTER

List your current over-the-counter medications

- ☐ Aspirin
- ☐ Antacids
- ☐ Allergyrelief
- ☐ Cold medicine
- ☐ Diet pills
- ☐ Laxatives
- ☐ Sleep aid
- ☐ Vitamins
- ☐ Supplements

- ☐ Other

ALLERGY RECORD

List all allergies and your reaction

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

IMMUNIZATION RECORD

Enter the date you were last immunized

Tetanus _____

Flu _____

Pneumonia _____

Hepatitis _____

Other _____

_____

_____

NOTES

Add any additional information here

NOTES

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