My Medical Information

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone (home): _____

Date of Birth: _____

Emergency Contact Name/Phone:

_____

Healthcare Proxy Name/Phone:

_____

Primary Care Physician's Name/Phone:

_____

Other Physician's Name/Phone:

_____

Other Physician's Name/Phone:

_____

Other Physician's Name/Phone:

_____

Pharmacy Name/Phone:

_____

Vaccination Dates:

Influenza	/ /
Tetanus	/ /
Pneumonia	/ /
Other	/ /
	/ /

Medications I cannot take & why:

_____

_____

_____

Allergies: _____

_____

_____

Other important health information:

_____

_____

_____

_____

_____

_____

Prescription Medications:

Name	Dose	Times

Prescription Medications:

Name	Dose	Times

Over-the-Counter Medications,
Vitamins, Herbal Supplements, etc.:

Name	Dose	Times