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

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

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

Keep a copy of this form in your File of Life mag.

Keep a copy of this form in your File of Life magnetic packet, which should be kept in your wallet or purse in case of emergency.

## EMERGENCY MEDICAL INFORMATION



Address:		
	th:	
Primary Care Doctor:		
Phone #:		
Preferred Pharmacy:		
Phone #:		
Medical Insurance Co.: Policy #:		
Other Medical Insurance:		
Policy #:		
Medicare / Medicaid:		
Policy #:		
Living Will: Yes / No		
Living Will: Yes / No  Health Care Power of Attorney: Ye	s / No	
Health Care Power of Attorney: Ye	s / No CY CONTACTS	
Health Care Power of Attorney: Ye  EMERGEN  Name:	CY CONTACTS  Phone #:	
Health Care Power of Attorney: Ye  EMERGEN	CY CONTACTS  Phone #:	
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Health Care Power of Attorney: Ye  EMERGEN  Name:  Address:  ame:  MEDIO	Phone #:  Phone #:  Phone #:	
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Health Care Power of Attorney: Ye  EMERGEN  Name:  Address:  ame:  MEDIO	Phone #:  Phone #:  Phone #:	
Health Care Power of Attorney: Ye  EMERGEN  Name:  Address:  ame:  MEDIO	Phone #:  Phone #:  Phone #:	

Tear on perforation and insert your updated File of Life form into your magnetic pocket.

Heart Disease	Lung Disease	Kidney DISEASE
CHF/Heart Failure	COPD/Emphysema	Failure
High Blood Pressure	Asthma	Insufficiency
Low Blood Pressure	Fibrosis	Dialysis
High Cholesterol	Pneumonia	Kidney Stones
Irregular Heart Beat	Bronchitis	Infections
Pacemaker	Shortness of Breath	
Heart Attack	Coughing	
Angina or Chest Pain	Lung Pain	
Heart Surgery/ ByPass/Stent		
STOMACH DISEASE	NEUROLOGICAL DISEASE	MALIGNANCY/ CANCER
Bowel Obstruction	Stroke	Lung
Bleeding	Bleeding in Brain	Liver
Diverticulitis	Seizures	Breast
Hiatal Hernia	Multiple Sclerosis	Stomach
GERD/Reflux	Parkinson	Leukemia
Diarrhea	Headaches	Colon
Blood in Stools	Alzheimers or	Skin
	Memory Loss	Other:
ENDOCRINE DISEASE	OTHER	
Diabetes	Arthritis	Vision
Thyroid:	Back Problem	Problems
High	HIV	Other
Low	Sickle Cell	
	Weight Gain	
	Weight Loss	

## Allergies (check all that apply)

Aspirin	Laytex	Tetracycline
Barbiturates	Lidocaine	X-Ray Dye
Codeine	Morphine	No Known Allergy
Demerol	Novocain	Other:
Insect Stings	Penicillin	
Horse Serum or	Sulfa	
Vaccines		

## UNIVERSAL MEDICATION FORM

(Use pencil on this form to allow for easy changing)

Date U <sub>1</sub>	odated:
Name:	
Address:	
Sex: Male / Female Date of Birth	h:
Primary Care Doctor:	
Phone #:	
Preferred Pharmacy:	
Phone #:	
Medical Insurance Co.:	
Policy #:	
Other Medical Insurance:	
Policy #:	
Medicare / Medicaid:	
MEDICINE ALLED CIEC/DI	
MEDICINE ALLERGIES/RI	EACTIONS (describe reaction)
Drug:	EACTIONS (describe reaction)  Reaction:
Drug:	Reaction:

