Important Medical Information

Courtesy Of: Proactive Health Advocates Healthcare Navigation

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Date Last Updated _____

Name _____

Address _____ **City** _____

State _____ **Zip Code** _____ **Phone** _____

Date of Birth _____

Medical Conditions

Allergies (medication, food, other)

Allergic To	Reaction	Allergic To	Reaction

Medication List (include prescription, over the counter, and herbal)

Medication Name & Strength	Dose	Frequency	Reason for Taking

Pharmacy

Name _____ Address _____

City _____ State _____ Zip Code _____ Phone _____

Hospitalizations (why**)/Surgeries (**what**)**

Hospitalization/Surgery	Year	Hospital/Facility

Emergency Contacts

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Physicians

	Name	Practice Name	Phone
PCP			
Specialist			
Specialist			
Specialist			
Specialist			
Specialist			
Specialist			
Specialist			
Specialist			
Specialist			

Assistive Devices

☐	Dentures	☐	Glasses	☐	Walker/Rollator	☐	Other
☐	Hearing Aids	☐	Contacts	☐	Wheelchair	☐	Other