UNIVERSAL MEDICATION FORM

(Use pencil on this form to allow foreasy changing or fill in on-line)

KEEP INFORMATION UP TO DATE!
Review At Least Every Six Months!

A copy of this form should be kept on your refrigerator and your wallet or purse in case of an emergency.

Date Updated:_____

Name:_____

Address:_____

Sex: Male / Female Date of Birth_____

Primary Care Doctor:_____

Phone#:_____

Preferred Pharmacy:_____

_____

Phone #:_____

Medical Insurance Co.:_____

Policy #:_____

Other Medical Insurance:_____

Policy #:_____

Medicare / Medicaid:_____

Policy#:_____

Living Will: Yes / No

Health Care Power of Attorney: Yes / No

EMERGENCY CONTACTS

Name:_____Phone#: _____

Address:_____

Name:_____Phone#:_____

Address:_____

MEDICAL DATA

Recent Surgeries / Hospitalizations:_____

Date:_____

_____

_____

MEDICAL DATA

Special Conditions/Remarks:

Medication	Dosage	Frequency

MEDICAL CONDITIONS (Check all that apply)

	No known medical conditions		Hemodialysis
	Abnormal EKG		Hemolytic Anemia
	Adrenal Insufficiency		Hepatitis-Type [ ]
	Angina/Chest Pain		Hypertension
	Asthma		Hypoglycemia
	Alzheimer's		Laryngectomy
	Bleeding Disorder		Leukemia
	Cancer		Lymphomas
	Cardiac Dysrhythmia		Memory Impaired
	Cataracts		Myasthenia Gravis
	Clotting Disorder		Pacemaker
	Coronary Bypass Graft		Renal Failure
	Dementia		Seizure Disorder
	Diabetes/ Insulin Dependent		Sickle Cell Anemia
	Eye Surgery		Stroke
	Glaucoma		Tuberculosis
	Hearing Impaired		Vision Impaired
	Heart Valve Prosthesis		
	Other:		

ALLERGIES

	Aspirin		Insect Stings		Penicillin
	Barbiturate		Latex		Sulfa
	Codeine		Lidocaine		Tetracycline
	Demerol		Morphine		X-Ray Dyes
	Horse Serum		Novocaine		No Known Allergies
	Environmental:				
	Other:				