Medication Information and Other Details

IHA

Name _____

Date of Birth _____ Blood Type _____

Address _____

City _____ State _____

Phone: Home _____ Work _____ Cell _____

In Case of Emergency (I.C.E.) Contacts:

Name _____

Phone _____ Relationship _____

Name _____

Phone _____ Relationship _____

Doctor: Name _____ Phone _____

List Specialist Names and Type (i.e., cardiologist, oncologist)

_____

_____

Pharmacy: Name _____ Phone _____

Vaccines: (Date of Last)

Flu _____ Hepatitis B: ❍ Yes ❍ No ❍ Don't Know

Pneumonia _____ Tetanus _____

Other Vaccinations _____

_____

_____

Tobacco Use: ❍ Yes ❍ No **If Yes, type:** ❍ cigarettes ❍ chew ❍ cigar ❍ pipe **Amount per day:** _____

Drug Allergies (What Happens When I Take It)

_____

_____

_____

_____

_____

Medical History and Surgeries

_____

_____

_____

_____

_____

Date Infrmation Updated: _____

Current Medications and Over-the-Counter Products

Medication Name	Dose	How Often Taken

Keep this list up to date and take to all health care visits.