

Emergency Contact / Phone#

Doctor(s) Please list below:

_____ /Phone # _____
_____ / Phone # _____
_____ / Phone # _____
_____ / Phone # _____

Pharmacy / Phone #

Vitamins / Supplements:

Over the Counter:

Latex **Contrast media (Iodine or IVP dye)**

Medications (include reactions)

Allergies and Reactions

Food (include reactions)

Environmental (include reactions)

Vaccinations

Influenza

2006 2007 2008

Pneumonia **Date** _____

Tetanus **Date** _____

Advance Directive Organ Donation

Yes **No** **Yes** **No**

Ongoing Medical Condition:

High Blood Pressure **Respiratory Problem**

Diabetes **Kidney Disease**

Heart Disease **Other:** _____