

MASSACHUSETTS MEDICAL SOCIETY

Massachusetts Coalition for the **Prevention of Medical Errors**

and update as needed.

- Review this with your doctor periodically

- Keep this with you at all times.
- Show this to your doctor at each visit.

Your Medical Information File

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🗆 St. John's Wort	211iq	nninaal2 🗌	znoitezihaM hlo2/dnuo2		
stnəməlqqu2 Vistəid/lediəH 🗌		evitexel 🗌	sənimstzihitnA\fəiləA Relier		
		Supplements	Over-the-Counter Medications and		
heria	tdqi0\zunst9T				

AMM AMM Pnerococcal Fretheria	□ Asthma □ Kidney Disease □ Diabetes □ High Blood Pressure □ Heart Disease □ Cancer □ Other □
Vaccinations (Date of Your Last Immunization)	Medical Conditions
	Emergency Contact

MEIGHT

Information About You • Please use pencil to complete this form.

Other Physicians/Specialists

Redical Contacts

этад нтяія RDDRESS YOUR NAME

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BLOOD TYPE

		🗌 Other (Be sure to list
Vitamins and Minerals	Antacids Difference Antacida Antacida	сура Кауа
/Headache/Fever 🗌 Diet Pills	Aspirin/Other for Pain/Headache/Fever 🗌 Diet Pills	sdolig Gingko Biloba
slli9 pniqəslZ 🗌 sn	slii9 pniqəəl2 🗌 snoitsəibəM bloJ/ApuoJ 🗌	□ St. John's Wort
zəvitexel 🗌 zənime	zəvitergy Relief/Antihistemines	Terbal/Dietary Supplements 🗌

on Medication List on back.)

anodq

HEIGHT

Date (mm/yy)	Allergy, Side Effects, Reaction, or Intolerance Experienced (Symptoms, Severity)	Medication/Food/Environment that Cause a Reaction				
	Discontinued Medications/Products (Due to Allergies, Side Effects, or Reactions)					

Medical Error Reduction • Massachusetts Medical Society Massachusetts Coalition for the Prevention of Medical Errors • Betsy Lehman Center for Patient Safety and

Health Insurance Plans						
Company Name	Other Information					

Important Health Care Documents					
Health Care Proxy	🗌 Yes	🗌 No			
If yes, where is the document located?					
 Health Care Durable Power of Attorney 	🗌 Yes	🗆 No			
If yes, where is the document located?					
Interested in organ or tissue donation?	🗌 Yes	🗌 No			

Medication List • Please use pencil to complete this form.			Patient Name:						
Start Date	Name of Medication	Prescribed By	Dosage	When is the medication taken?	Purpose	Danger Signs*	Stop Date	Monitoring Required	Notes/ Changes
mm/dd/yy	Brand and Generic Name (If Available)	(Physician's Name)	mg/units/ puffs/drops	How many times per day? Morning and/or night? After meals?		Call immediately if you experience any of these signs.	mm/dd/yy	(e.g., lab test every weeks)	Patient, have you experienced any side effects? If stopped taking, why? Doctor, identify drugs and/or food that may cause interactions. Date list was reviewed/updated:

* Always refer to physician and pharmacist input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list. After any hospitalization, check with your doctor to review this medication list.

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