

YOUR NAME			
ADDRESS			
BIRTH DATE			
BLOOD TYPE			
WEIGHT			
HEIGHT			
Medical Contacts		Name	Phone
Pharmacy			
Primary Care Physician			
Other Physicians/Specialists			
Emergency Contact			
Medical Conditions		Vaccinations (Date of Your Last Immunization)	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Influenza	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> MMR	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Pneumococcal	
<input type="checkbox"/> Other		<input type="checkbox"/> Tetanus/Diphtheria	

Over-the-Counter Medications and Supplements	
<input type="checkbox"/> Allergy Relief/Antihistamines	<input type="checkbox"/> Laxatives
<input type="checkbox"/> Cough/Cold Medications	<input type="checkbox"/> Sleeping Pills
<input type="checkbox"/> Aspirin/Other for Pain/Headache/Fever	<input type="checkbox"/> Diet Pills
<input type="checkbox"/> Antacids	<input type="checkbox"/> Vitamins and Minerals
<input type="checkbox"/> Herbal/Dietary Supplements	
<input type="checkbox"/> St. John's Wort	
<input type="checkbox"/> Ginkgo Biloba	
<input type="checkbox"/> Kava Kava	
<input type="checkbox"/> Other (Be sure to list on Medication List on back.)	

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

Important Health Care Documents		
• Health Care Proxy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, where is the document located?		
• Health Care Durable Power of Attorney	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, where is the document located?		
• Interested in organ or tissue donation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Health Insurance Plans	
Company Name	Other Information


Questions to Ask Your Doctor

Your Medical Information File

- Show this to your doctor at each visit.
- Keep this with you at all times.
- Review this with your doctor periodically and update as needed.

Compliments of:



MASSACHUSETTS MEDICAL SOCIETY

Massachusetts Coalition for the Prevention of Medical Errors

## Medication List

- Please use pencil to complete this form.

Patient Name: \_\_\_\_\_

[illegible]

\* 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.