

MEDICAL INFORMATION FILE

NAME _____	DATE OF BIRTH _____
ADDRESS _____	TEL. _____
PHARMACY(IES) _____	TEL. _____
DIAGNOSIS(ES) OR MEDICAL STATUS _____	
ALLERGIES – FOOD/ENVIRONMENTAL _____	
ALLERGIES – DRUG _____	
PHYSICIAN _____	TEL. _____
IN CASE OF EMERGENCY _____	TEL. _____
HEALTH INSURANCE _____	POLICY NO. _____
HEALTH CARE PROXY <input type="checkbox"/> YES <input type="checkbox"/> NO LOCATION OF DOCUMENT _____	
NAME OF AGENT _____	TEL. _____
LIVING WILL <input type="checkbox"/> YES <input type="checkbox"/> NO	THIS MEDIFILE WAS LAST REVISED ON _____

(Note: not statutorily recognized in Massachusetts)

LIST ALL MEDICATIONS, HERBAL REMEDIES, AND VITAMIN SUPPLEMENTS YOU ARE TAKING.

PRESCRIPTION MEDICATION

OVER-THE-COUNTER MEDICATION

HERBAL REMEDIES/VITAMIN SUPPLEMENTS

ADDITIONAL INFORMATION

- **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.

THINGS TO REMEMBER

- Understand how to take a medicine, when, with food or on an empty stomach.
- Ask what foods, beverages (including alcohol), and medications should be avoided.
- Ask how to store your medicine.
- Finish the medicine you are taking for the prescribed time period.
- Don't take anyone else's medicine.
- Dispose of all outdated medicines.

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*Every physician matters,
each patient counts.*



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