

MEDICAL CONDITIONS

(check all that apply)

HEART DISEASE		LUNG DISEASE		KIDNEY DISEASE	
<input type="checkbox"/>	CHF/Heart Failure	<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	Failure
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Insufficiency
<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Fibrosis	<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Infections
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	
<input type="checkbox"/>	Angina or Chest Pain	<input type="checkbox"/>	Lung Pain	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Surgery/ ByPass/Stent	<input type="checkbox"/>		<input type="checkbox"/>	
STOMACH DISEASE		NEUROLOGICAL DISEASE		MALIGNANCY/ CANCER	
<input type="checkbox"/>	Bowel Obstruction	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Lung
<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Bleeding in Brain	<input type="checkbox"/>	Liver
<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Breast
<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Stomach
<input type="checkbox"/>	GERD/Reflux	<input type="checkbox"/>	Parkinson	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Colon
<input type="checkbox"/>	Blood in Stools	<input type="checkbox"/>	Alzheimers or	<input type="checkbox"/>	Skin
<input type="checkbox"/>		<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	Other:
ENDOCRINE DISEASE		OTHER			
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Vision
<input type="checkbox"/>	Thyroid:	<input type="checkbox"/>	Back Problem	<input type="checkbox"/>	Problems
<input type="checkbox"/>	_____ High	<input type="checkbox"/>	HIV	<input type="checkbox"/>	Other
<input type="checkbox"/>	_____ Low	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	

ALLERGIES

(check all that apply)

<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	Lidocaine	<input type="checkbox"/>	X-Ray Dye
<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	No Known Allergy
<input type="checkbox"/>	Demerol	<input type="checkbox"/>	Novocain	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Insect Stings	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	
<input type="checkbox"/>	Horse Serum or	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	
<input type="checkbox"/>	Vaccines	<input type="checkbox"/>		<input type="checkbox"/>	

Update this form whenever you have a change of medication or medical history.

Keep a copy of this form in your File of Life magnetic packet, which should be placed on your refrigerator. A copy of this form also should be kept in your wallet or purse in case of emergency.

UNIVERSAL MEDICATION FORM

(Use pencil on this form to allow for easy changing)

Date Updated: _____

Name: _____

Address: _____

Sex: Male / Female Date of Birth: _____

Primary Care Doctor: _____

Phone #: _____

Preferred Pharmacy: _____

Phone #: _____

Medical Insurance Co.: _____

Policy #: _____

Other Medical Insurance: _____

Policy #: _____

Medicare / Medicaid: _____

Policy #: _____

MEDICINE ALLERGIES/REACTIONS (describe reaction)

Drug: _____ Reaction: _____
