LIST ALL MEDICINES YOU ARE CURRENTLY TAKING

Please list prescriptions and over-the-counter medications (ex: aspirin, antacids) and herbals (ex: ginseng, ginkgo). Make sure you include medications that you are taking routinely and "as needed."

Name of prescription, Over-the-counter medication, vitamins/supplements & dose	How Often You Take	Reason For Taking

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.

EMERGENCY MEDICAL INFORMATION

Provided by Marengo Fire and Marengo Rescue Districts
Marengo, Illinois

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 #: _____

Living Will: Yes / No

Health Care Power of Attorney: Yes / No

EMERGENCY CONTACTS

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

MEDICAL DATA

Recent Surgeries/Hospitalizations: _____ Date: _____

_____

_____

_____

_____

(over)

Tear on perforation and insert your updated File of Life form into your magnetic pocket.

MEDICAL CONDITIONS

(check all that apply)

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

ALLERGIES

(check all that apply)

	Aspirin		Latex		Tetracycline
	Barbiturates		Lidocaine		X-Ray Dye
	Codeine		Morphine		No Known Allergy
	Demerol		Novocain		Other:
	Insect Stings		Penicillin		
	Horse Serum or		Sulfa		
	Vaccines				

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: