health-at-a-glance

Name_____ Date of Birth_____

DRUG ALLERGIES/REACTIONS _____

MEDICAL CONDITIONS _____

ALL MEDICATIONS AND SUPPLEMENTS TAKEN DAILY OR OCCASIONALLY
(NAME, DOSE, DIRECTIONS)

DATE OF LAST VACCINATIONS

Tetanus_____ Pneumonia _____ Flu _____

Other _____

FAMILY DOCTOR/PRIMARY CARE PRACTITIONER

Name _____ Telephone _____

Address _____ E-mail _____

EMERGENCY CONTACT

Name _____ Telephone _____

Address _____ E-mail _____

LIVING WILL ☐ Yes ☐ No Are you an Organ Donor? ☐ Yes ☐ No

DURABLE POWER OF ATTORNEY

Name _____ Telephone _____

Address _____

■ **CARRY A COPY OF YOUR EKG, ESPECIALLY IF IT IS ABNORMAL.**