Medical Information

Keep this information with your health insurance card.

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____

☐ Male ☐ Female Date of Birth _____

Today's date _____

Emergency Contacts

Name _____

Relation _____ Phone _____

Name _____

Relation _____ Phone _____

My Doctor Contacts

Name _____

Specialty _____ Phone _____

Name _____

Specialty _____ Phone _____

Name _____

Specialty _____ Phone _____

Allergies

_____

_____

_____

_____

_____

Immunizations

Date of Last:

Tetanus _____

Flu _____

Pneumonia _____

Hepatitis B _____

Other _____

Other _____

www.indypatientsafety.org

I am currently being treated for:

_____

_____

_____

_____

_____

_____

_____

My Neighborhood and Mail Order Pharmacy

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____

Indianapolis Coalition for Patient Safety

Committed to Excellence

Current Medicines

Keep medicines list updated. Cross off medicines your doctor does not want you to take

Prescribed Medicines

	Name	Dosage	How often	Date Started / Date Stopped	Reasons for Taking
EXAMPLE:	Amoxicillin	500-mg	3x per day/ 2 weeks	1-5- 2010/ 1-19- 2010	Ear Infection

Vitamins and Herbal Supplements

Name	Dosage	How often	Date Started / Date Stopped	Reasons for Taking

Other Medicines Not Prescribed By Doctor

Name	Dosage	How often	Date Started / Date Stopped	Reasons for Taking