My Health Information

IMPORTANT INFORMATION

Patient Name/Number: _____

Emergency Contact Name/Number: _____

Primary Care Provider Name/Number: _____

Pharmacy Name/Number: _____

Allergies: _____

_____

Schedule and go to my doctor appointments

Be sure my doctor has seen my test results

Bring a current list of medications to my appointments

MY NEXT APPOINTMENT

Where: _____

Date/Time: _____

Reason for Visit: _____

Things to Bring: _____

Questions to Remember: _____

_____

MEDICATIONS LIST (take all medicines as directed)

INCLUDE: prescription medications, over-the-counter medications, herbals, vitamins, and supplements

Name of medicine										
Dose (amount)										
How often and when? (for example: morning, noon, evening)										
How to take (for example: with or without food)										
Reason for taking										

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In Case of an Emergency: Call 911