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."

(Use your computer to complete this section)

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 shouldbe placed on your refrigerator. A copy of this form also should be kept in your wallet or purse in case of emergency. For additional copies of this form or to receive a new magnetic packet.

_____

EMERGENCY MEDICAL INFORMATION

Andrew County Ambulance District

For Emergencies Call 911

For Assistance Filling or Updating card: **(816) 897-0549**
www.academs.org

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)

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 Problems
☐ Thyroid:	☐ Back Problems	☐ Other
☐ High	☐ HIV	☐ Other
☐ Low	☐ Sickle Cell	
	☐ Weight Gain	
	☐ Weight Loss	

ALLERGIES

(check all that apply)

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

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 shouldbe 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:

Save Form As... Print Form