Medical History At-a-Glance

Last Name:	M.I.:	First Name:	
Social Security Number		Date of Birth	_ _/ _ _/ _ _ _ _

Doctor's Name	Office Address	Phone Number	Type of Doctor

Prescription Information

Drug	Dosage	When do you take it?	Type of medicine

Pharmacy	Address:	Phone:
Allergies		
Preferred Hospital		Insurance Provider
Are you an organ donor?	□ yes □ no	Do you have a DNR? □ yes □ no

Recent surgery/ procedure/ exam/ hospital stay	Location	Dates	Comments

Emergency Contact:	Phone:	Relationship:

NOTE: This page may be filed with important documents, brought to doctor's appointments, and/or given to family members and POA's. Please keep sensitive information secure at all times.