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."

Name of prescription, Over-the- counter medication, vitamins/supplements & dose	How Often You Take	Reason for Taking
vitaminis/supprements & dose		

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 should be 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, please contact Greenwich EMS Community Outreach Dept. 203-637-7505 This form can also be obtained and filled out online at www.greenwichems.org



Date updated:		
Name:		
Address:		
City:		
Date of Birth:		Sex: 🗖 Male / 🗖 Female
Primary Care Doctor:		
Phone #:		
Preferred Pharmacy:		
Phone #:		
Medical Insurance Co.:		
Policy #:		
Other Medical Insurance:		
Policy #:		
Medicare:		
Medicaid:		
Policy #:		
Living Will: \Box Yes / \Box N	0	
Health Care Power of Attorney:	□ Ye	es / 🗖 No

EMERGENCY CONTACTS

Name:	 	
Name:	 	
Phone #:	 	
Address:		

MEDICAL DATA

Recent Surgeries/Hospitalizations:	Date:

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 / By- pass / Stent		
STOMACH	NEUROLOGICAL	MALIGNANCY/
DISEASE	DISEASE	CANCER
Bowel Obstruction	Stroke	Lung
Bleeding	Bleeding in Brain	Liver
Diverticulitis	Seizures	Breast
Hiatal Hernia	Multiple Sclerosis	Stomach
GERD/Ref lux	Parkinson	Leukemia
Diarrhea	Headaches	Colon
Blood in Stools	Alzheimer's	Skin
	Memory Loss	Other:
ENDOCRINE DISEASE	OTHER	
Diabetes	Arthritis	Vision
Thyroid:	Back Problem	Problems
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		Sulfa		
Vaccines				

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Date updated:	
Name:	
Address:	
City:	
Date of Birth:	 Sex: 🗖 Male / 🗖 Female
Primary Care Doctor:	
Phone #:	
Preferred Pharmacy:	
Phone #:	
Medical Insurance Co.:	
Policy #:	
Other Medical Insurance:	
Policy #:	
Medicare:	
Policy #:	
Medicaid:	
Policy #:	

MEDICINE ALLERGIES/REACTIONS

(describe reaction)

<u>Drug:</u>	Reaction: