

Keep in wallet.

Personal Information Name: Date of Birth: Physician: **Emergency Contacts:** 1. Name: Phone: 2. Name: Phone: 3. Name: Phone: **Pertinent Medical History** Allergies (food and drug)

Be sure you discuss your medication questions with your pharmacist and/or physician.

• Medications List •												
											Example: Lipitor	Drug Name
											Example: 20 mg	Dose
											Example: Daily	How often taken
												ken
											Example: Cholesterol	Why