File for Life

Patient Name: _____ Date of Birth: _____

Primary Physician: _____ Pharmacy: _____

LATEX ALLERGY: YES NO

(circle one)

Medicine Allergies: _____

Medical Conditions: _____

Please list all medications, prescription and nonprescription vitamins, herbs and supplements.
If you stop taking any of these medicines, please draw a line through them.

Name of Medication	Dose	Frequency	What is medicine for?

Fill out this form to keep on your refrigerator. In case of a medical emergency, give to emergency medical personnel.