First Fold

IMMUNIZATIONS

Vaccine	Date of last dose
☐ Pneumonia Vaccine:	________________
☐ Flu Vaccine(s):	________________
☐ Tetanus:	________________

Important Medical Problems:

☐ Diabetes
☐ Kidney Disease
☐ High Blood Pressure
☐ Other ____________________________________
☐ Liver Disease
☐ Heart Disease

Emergency Phone Numbers:

Primary Doctor: ________________________________

Phone: ________________________________

Other Doctor: ________________________________

Phone: ________________________________

Pharmacy: ________________________________

Pharmacy Phone: ________________________________

Second Fold

☐ I have no known allergies OR
☐ I Am Allergic To:

List your allergies:	The reaction I have is:

Patient Name: ________________________________

Phone Number: ________________________________

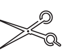
In case of Emergency, please contact:

Name: ________________________________

Phone Number: ________________________________

Forms available at www.gha.org/pha

Cut on dotted line



MEDICATIONS:

List all prescription medications.

Include medications taken as needed

(example: nitroglycerine)

Name of Medication Add each new medication	Dose or Strength	Amount Taken or How Much	How Often or Time of Day Taken	Why Taking

If you stop a medication, cross it off the list.

First Fold

OVER-THE-COUNTER MEDICATIONS:

Like: aspirin, antacids, cold or cough medicine, creams, inhalers, vitamins, and herbals like ginseng or gingko.

Name	Dose or Strength	Amount Taken or How Much	How Often or Time of Day Taken	Why Taking

Second Fold