Medical Information

Name

Street Address

City and State

___/___/____
Date of Birth

Emergency contact name and phone

Physician name and phone

Pharmacy phone

My medications (including vitamins, herbs and over-the-counter drugs)

Drug name *example: Zocor*	Dose *20 mg*	How often? *1x day, AM*

Allergies and medication reactions

Other important health information

Other physicians and pharmacies

Bring this list to healthcare appointments and to the hospital. Keep a copy in your purse or wallet and where others can find it – on your refrigerator and in your car's glove box. For more blank forms, call Clinch Valley Medical Center at (276) 596-6025 or Ask.CVMC@LPNT.net.