HEALTH FACTS CARD

DATE LAST CHANGED: _________ (USE A PENCIL)

Take this card to all Doctor, Hospital and Pharmacy visits

For re-orders: www.qchealthinitiative.org

Name:_______________________________Sex: M F

Address: ____________________________________

____

Date Of Birth:___/__/____Height: ____ Weight:______

EMERGENCY CONTACTS

Name:____________________ Phone:____________

Address:____________________________________

Relation:________________Work Phone:__________

Name:______________________Phone:__________

Address:____________________________________

Relation:________________Work Phone:___________

MEDICAL DATA

LAST UPDATED: Mo.___________Yr.______________

Doctor:______________________Phone:___________

Doctor:______________________Phone:___________

Hospital Preference:_____________________________

Advance Directive: _______Yes ________ No

On File at: __________________________________

____

Recent Surgery:________________Date:__________

____

____

IMMUNIZATIONS

Tetanus: ___/__/____ Pneumonia: ___/__/____

Influenza: ___/__/____ Other: __________ ___/__/____

MEDICAL CONDITIONS

Check all that exist

- ☐ No known medical conditions
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ COPD / Emphysema
- ☐ Coronary Bypass Graft
- ☐ Dementia
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hearing Impaired
- ☐ High Blood Pressure
- ☐ Kidney Failure
- ☐ Low Blood Sugar
- ☐ Pacemaker
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision Impaired
- ☐ Other Risk Factors

____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Tetanus
- ☐ Environmental: ______________
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Iodine
- ☐ Penicillin
- ☐ Shellfish
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Rays Dyes
- ☐ Other ____________
- ☐ No Allergies

MEDICATIONS ON REVERSE SIDE

List all medications you are taking, including herbals and over the counter drugs. Cross off discontinued medicines. Use an additional page if necessary.

Medication Name & Dose	Times/day	Date Started	What is it For?	Prescribing Doctor	Pharmacy & Phone #

Date last changed: _______________ MAKE SURE TO CROSS OFF DISCONTINUED MEDICINES.