

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING

Please list prescriptions and over-the-counter medications (ex: aspirin, antacids) and herbals (ex: ginseng, ginkgo). Make sure you include medications that you are taking routinely and "as needed."

Name of prescription, Over-the-counter medication, vitamins/supplements & dose	How Often You Take	Reason For Taking

Update this form whenever you have a change of medication or medical history.

Keep a copy of this form in your File of Life magnetic packet, which should be placed on your refrigerator. A copy of this form also should be kept in your wallet or purse in case of emergency. For additional copies of this form or to receive a new magnetic packet, please contact Beebe Medical Center's Community Relations Dept. at 302-645-3468. This form can also be obtained and filled out online at www.beebemed.org.

EMERGENCY MEDICAL INFORMATION



Beebe Medical Center

In cooperation with: Sussex County Sheriff's Dept.,
Sussex County Senior Services, Local Vol. Fire and Ambulance Companies, & Delaware State Police
(Use your computer to complete this section)

Date Updated: _____

Name: _____

Address: _____

Sex: Male / Female Date of Birth: _____

Primary Care Doctor: _____

Phone #: _____

Preferred Pharmacy: _____

Phone #: _____

Medical Insurance Co.: _____
Policy #: _____

Other Medical Insurance: _____
Policy #: _____

Medicare / Medicaid: _____
Policy #: _____

Living Will: Yes / No

Health Care Power of Attorney: Yes / No

EMERGENCY CONTACTS

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

MEDICAL DATA

Recent Surgeries/Hospitalizations: _____ Date: _____

(over)

Tear on perforation and insert your updated File of Life form into your magnetic pocket.

MEDICAL CONDITIONS

(check all that apply)

HEART DISEASE		LUNG DISEASE		KIDNEY DISEASE	
<input type="checkbox"/>	CHF/Heart Failure	<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	Failure
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Insufficiency
<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Fibrosis	<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Infections
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	
<input type="checkbox"/>	Angina or Chest Pain	<input type="checkbox"/>	Lung Pain	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Surgery/ ByPass/Stent	<input type="checkbox"/>		<input type="checkbox"/>	
STOMACH DISEASE		NEUROLOGICAL DISEASE		MALIGNANCY/ CANCER	
<input type="checkbox"/>	Bowel Obstruction	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Lung
<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Bleeding in Brain	<input type="checkbox"/>	Liver
<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Breast
<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Stomach
<input type="checkbox"/>	GERD/Reflux	<input type="checkbox"/>	Parkinson	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Colon
<input type="checkbox"/>	Blood in Stools	<input type="checkbox"/>	Alzheimers or	<input type="checkbox"/>	Skin
<input type="checkbox"/>		<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	Other:
ENDOCRINE DISEASE		OTHER			
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Vision
<input type="checkbox"/>	Thyroid:	<input type="checkbox"/>	Back Problem	<input type="checkbox"/>	Problems
<input type="checkbox"/>	_____ High	<input type="checkbox"/>	HIV	<input type="checkbox"/>	Other
<input type="checkbox"/>	_____ Low	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	

ALLERGIES

(check all that apply)

<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Laytex	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	Lidocaine	<input type="checkbox"/>	X-Ray Dye
<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	No Known Allergy
<input type="checkbox"/>	Demerol	<input type="checkbox"/>	Novocain	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Insect Stings	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	
<input type="checkbox"/>	Horse Serum or	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	
<input type="checkbox"/>	Vaccines	<input type="checkbox"/>		<input type="checkbox"/>	

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UNIVERSAL MEDICATION FORM

(Use pencil on this form to allow for easy changing)

Date Updated: _____

Name: _____

Address: _____

Sex: Male / Female Date of Birth: _____

Primary Care Doctor: _____

Phone #: _____

Preferred Pharmacy: _____

Phone #: _____

Medical Insurance Co.: _____

Policy #: _____

Other Medical Insurance: _____

Policy #: _____

Medicare / Medicaid: _____

Policy #: _____

MEDICINE ALLERGIES/REACTIONS (describe reaction)

Drug: _____ Reaction: _____
