

(Note: not statutorily recognized in Massachusetts)

Name _____

Address _____

Tel. _____

Date of Birth _____

Pharmacy(ies) _____

Tel. _____

Diagnosis(es) or Medical Status _____

Allergies – Food/Environmental _____

Allergies – Drug _____

Physician _____

Tel. _____

In Case of Emergency _____

Tel. _____

Health Insurance _____

Policy No. _____

Health Care Proxy Yes No Location of Document _____

Name of Agent _____

Tel. _____

Living Will Yes No

This Medifile was last revised on _____

THINGS TO REMEMBER

- Understand how to take a medicine, when, with food or on an empty stomach.
- Ask what foods, beverages (including alcohol), and medications should be avoided.
- Ask how to store your medicine.
- Finish the medicine you are taking for the prescribed time period.
- Don't take anyone else's medicine.
- Dispose of all outdated medicines.

MEDICAL INFORMATION FILE

- **SHOW** this to your doctor at each visit.
- **KEEP** this with you at all times.
- **REVIEW** this with your doctor periodically and update as needed.

Compliments of



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MEDICAL SOCIETY



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ALLIANCE

PRINT ALL MEDICATIONS, HERBAL REMEDIES, AND VITAMIN SUPPLEMENTS YOU ARE TAKING.

PRESCRIPTION MEDICATION	DOSE	FREQUENCY	PRESCRIBED BY	DATE	PURPOSE
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OVER-THE-COUNTER MEDICATION	DOSE	FREQUENCY	PRESCRIBED BY	DATE	PURPOSE
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HERBAL REMEDIES/VITAMIN SUPPLEMENTS

ADDITIONAL INFORMATION *(e.g., adverse reactions experienced)*
