My Medication Card

Name: _____

Address: _____

_____

_____

Phone: _____

Date of Birth: _____

Insurance: _____

Policy No: _____

Group No.: _____

Organ Donation? Y/N

Advanced Directives? Y/N

Please place in your wallet and carry with you at all times

Emergency Contacts

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

Physician's Name: _____

Physician's Phone: _____

Pharmacy: _____

Pharmacy Phone: _____

Valley View Hospital
1906 Blake Ave.
Glenwood Springs, CO 81601
970.384.6535

Medical History

Please check all that apply

☐ Asthma ☐ Lung Disease
☐ Diabetes ☐ Kidney Disease
☐ High Blood Pressure ☐ Heart Disease
☐ Cancer/Type _____

Surgeries/Dates: _____

_____

_____

Other Conditions: _____

_____

_____

Implantable Devices

(pacemaker, stent, medipport, joints)
List where, when & brand.

_____

_____

_____

Allergies - Drug, Food, Latex

☐ No known allergies

Allergic to: _____
Reaction: _____

Allergic to: _____
Reaction: _____

Allergic to: _____
Reaction: _____

Allergic to: _____
Reaction: _____

Immunization Record

Tetanus shot? Y/N Date: _____
Flu shot? Y/N Date: _____
Pneumonia vaccine? Y/N Date: _____
Hepatitis B vaccine? Y/N Date: _____

Name of Medication & Strength *Brand name, generic name, over-the-counter, herbals, vitamins, injections, eye drops, creams*	**Dose** *How many tabs; puffs, etc.*	**Frequency** *How often*

Whenever you see your doctors please update this medication list.

Patients Name: _____