

# Key Medical Information

Primary doctor:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_

Health Insurance:

Policy \_\_\_\_\_

Policy Number \_\_\_\_\_

Phone \_\_\_\_\_

Location of Medicare and/or Health Insurance Cards \_\_\_\_\_

Blood type \_\_\_\_\_

Medications and location \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Past treatments or surgeries \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Conditions you should be aware of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Location of my medical records \_\_\_\_\_

Location of organ donor information \_\_\_\_\_

Additional medical information \_\_\_\_\_

\_\_\_\_\_