

STEP 1.

Print MedCard on 1 page – print on front and back.

STEP 2.

Trim MedCard edges – cut along dotted line:

MedCard for:

Name: _____

 Date of birth: _____
 Phone: _____

Emergency Contact

Name: _____
 Phone: _____

To get more cards contact the Iowa Healthcare Collaborative at www.ihonline.org.

My Health Conditions:

Arthritis
 Diabetes
 Cancer
 Stroke
 Seizures
 Lung problems
 Heart problems
 High blood pressure
 Kidney problems
 Do you smoke? Last quit attempt ___/___/___

Liver problems
 Joint replacement
 Contact lenses
 Dentures/partials
 Lens implant (in my eye)
 Pacemaker (for my heart)
 Defibrillator (for my heart)
 Hearing aid
 Other: _____

Advance Directives I Have

Living Will
 Durable Power of Attorney for Health Care
 Neither

Always ask:

1. What is the name of the medicine? What is it for?
2. How and when do I take it? How long do I take it?
3. Do I need to stay away from any foods, drinks, other medicines or activities while I take this medicine?
4. Are there any side effects? What do I do if they happen?
5. Where can I find out more about this medicine?

Past Surgeries (Operations)	Year

Allergies (Medicine, Food, Latex, other)	Reaction (What happens)

My Doctor and Pharmacy

Doctor's Name: _____
 Doctor's Phone Number: _____
 Pharmacy Name: _____
 Pharmacy Phone Number: _____
 Other Doctors:
 (specialists) _____

Vaccination Dates: Flu: _____
 Tetanus: _____ Pneumonia: _____
 MMR: _____ Tetanus/diphtheria: _____

STEP 3.

Fold MedCard in half along dotted line:

MedCard for:

Name: _____

Date of birth: _____

Phone: _____

Emergency Contact

Name: _____

Phone: _____

To get more cards contact the Iowa Healthcare Collaborative at www.ihoonline.org

My Health Conditions:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Dentures/partials |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lens implant (in my eye) |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Pacemaker (for my heart) |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Defibrillator (for my heart) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Do you smoke? Last quit attempt <u> </u> / <u> </u> / <u> </u> | |

Advance Directives I Have

- Living Will
 Durable Power of Attorney for Health Care
 Neither

Always ask:

1. What is the name of the medicine? What is it for?
2. How and when do I take it? How long do I take it?
3. Do I need to stay away from any foods, drinks, other medicines or activities while I take this medicine?
4. Are there any side effects? What do I do if they happen?
5. Where can I find out more about this medicine?

Past Surgeries (Operations)		Year
Allergies <small>(Medicine, Food, Latex, other)</small>	Reaction <small>(What happens)</small>	

My Doctor and Pharmacy	
Doctor's Name: _____	
Doctor's Phone Number: _____	
Pharmacy Name: _____	
Pharmacy Phone Number: _____	
Other Doctors: _____ (specialists)	
Vaccination Dates:	Flu: _____
Tetanus: _____	Pneumonia: _____
MMR: _____	Tetanus/diphtheria: _____

STEP 4.

Fold MedCard into quarters along dotted lines:

MedCard for:

Name: _____

Date of birth: _____

Phone: _____

Emergency Contact

Name: _____

Phone: _____

To get more cards contact the Iowa Healthcare Collaborative at www.ihoonline.org

My Health Conditions:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Dentures/partials |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lens implant (in my eye) |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Pacemaker (for my heart) |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Defibrillator (for my heart) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Do you smoke? Last quit attempt <u> </u> / <u> </u> / <u> </u> | |

Advance Directives I Have

- Living Will
 Durable Power of Attorney for Health Care
 Neither

Always ask:

1. What is the name of the medicine? What is it for?
2. How and when do I take it? How long do I take it?
3. Do I need to stay away from any foods, drinks, other medicines or activities while I take this medicine?
4. Are there any side effects? What do I do if they happen?
5. Where can I find out more about this medicine?