

# MedCard for:

Name: \_\_\_\_\_

\_\_\_\_\_

Date of birth: \_\_\_\_\_

Phone: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

To get more cards contact the  
Iowa Healthcare Collaborative at  
[www.ihconline.org](http://www.ihconline.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/partial             |
| <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 (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: \_\_\_\_\_

**Personal Medicine Record for:** \_\_\_\_\_

- Use a pencil.
- Do not list medicines I will take for less than two weeks (example: antibiotics).
- List all medicines I take, including prescriptions, eye drops, inhalers/nebulizers, oxygen, creams and ointments, birth control pills, etc.

Date added or changed	Medicine	How much? (Strength/ Dosage)	How often do I take it?	What is it for?	Doctor who prescribed it

**Over-the-Counter Medicines (medicines you can buy without a doctor's order):** (Check all that you use regularly.)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Allergy medicine, antihistamines    | <input type="checkbox"/> Cold/cough medicines                   | <input type="checkbox"/> Laxatives          | <input type="checkbox"/> Pain, headache or fever medicine |
| <input type="checkbox"/> Antacids (for heartburn or stomach) | <input type="checkbox"/> Diet pills                             | <input type="checkbox"/> Sleeping pills     | <input type="checkbox"/> Other (List): _____              |
| <input type="checkbox"/> Aspirin                             | <input type="checkbox"/> Herbals, dietary supplements, hormones | <input type="checkbox"/> Vitamins, minerals | _____   |

- Always:**
- ✓ Keep this card with you.
  - ✓ Give this card to your doctor to be checked and updated.
  - ✓ Always give this card to your pharmacist when you get a new medicine.
  - ✓ Keep insurance cards with this card.
  - ✓ Use the same pharmacy if you can.