Important Healthcare Documents

☐ Health Care Proxy ☐ Other _____

Health Insurance Plans

Plan Name _____ Policy Number _____

Plan Name _____ Policy Number _____

Allergies, Side Effects, or Reactions

Medication/Food/Environment that causes reaction	Allergy, Side Effects, Reaction or Intolerance Experienced (symptoms, severity)	Date of Event (mm/yy)

Over-the-Counter Medications and other Supplements

☐ Allergy Relief/Antihistamine ☐ Antacids ☐ Aspirin/Other for Pain/Headache/Fever ☐ Diet Pills

☐ Cough/Cold Medications ☐ Vitamins/Minerals ☐ Laxatives ☐ Sleeping Pills ☐ Fish Oil

☐ Herbal/Dietary ☐ Supplements ☐ St. John's Wort ☐ Gingko Biloba ☐ Kava Kava

☐ Other (please list) _____

_____

TAKE YOUR MEDICATIONS FOR A CHECKUP

Take Your Medications for a Checkup is a service provided by Circle Health.

For help completing this form or to download a new document, please visit our website at www.lowellgeneral.org/takeyourmedsforacheckup

Name _____

Address _____

Birth Date _____ Blood Type _____ Weight _____ Height _____

Medical Contacts

Pharmacy _____ Phone _____

Primary Care Physician _____ Phone _____

Other Physicians/Specialists _____ Phone _____

_____ Phone _____

_____ Phone _____

Emergency Contact _____ Phone _____

Medical Conditions

☐ Kidney Disease ☐ Heart Disease ☐ Medical Devices ☐ High Blood Pressure

☐ Asthma ☐ Cancer ☐ Diabetes

☐ Other (please list) _____

_____

Vaccinations (please note the date of the immunizations)

Influenza _____ Pneumococcal _____

MMR _____ Tetanus/Diphtheria _____

My Medication List *Please use pencil to complete this form*

	Start Date	Name of Medication	Prescribed by	Dosage	When is the Medication Taken?	Purpose	Danger Signs*	Stop Date	Monitoring Required	Notes/Changes
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

1. **Always keep this form with you.**
2. Take this form to ALL doctor visits, ALL medical testing (lab, x-ray, MRI, CT, etc.) pre-assessment visits for admission or surgery, and ALL hospital visits (ER, in-patient admission, out-patient visits)
3. Update this form with medication changes. If a medication is stopped, draw a line through it and record the date it was stopped. If you need help filling out this form, ask a physician, nurse, pharmacist, friend or family member.
4. In the NOTES/CHANGES column, record things like the name of the doctor who told you to take this medication. You may also add the reason for taking the medication (high blood pressure, nerves, sleep…). Always keep this form with you.
5. Tell your family, friends and neighbors about the benefits of using this form.
6. When you are discharged from the hospital, update your form. When you return to your primary care physician or see a specialist, take your updated form with you. Always keep this this form with you. This will keep everyone up-to-date on your medications.

circlehealth
Complete connected care℠

**Refer to physician input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. After any hospitalization, check with your doctor to review this medication list. For assistance visit www.lowellgeneral.org or call 1-877-LGH-WELL (1-877-544-8355).*