PHYSICIAN INFORMATION

Please list all of the physicians who are currently providing care to you:

Physicians:	Phone:

Please contact the person(s) or organization(s) listed below for information on living will or donor information:

Durable Power of Attorney for Health Care ☐ Yes ☐ No

Advance Directive ☐ Yes ☐ No

Name: ______________________________

Phone: ______________________________

Name of Homecare Agency: ______________________________

Date of your last tetanus shot ______________

Date of your last pneumonia shot ______________

Date of your last flu shot ______________

Do you use C-PAP or Bi-PAP ☐ Yes ☐ No

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________

Phone: ______________________________

Birthdate: ______________ ☐ Male ☐ Female

Date this medical form was completed: ______________

Organ Donor ☐ Yes ☐ No

EMERGENCY MEDICAL RECORD

400 West Seventh Street • Frederick, Maryland 21701
www.fmh.org • 240-566-3300

Attention: Police / Medical

IN CASE OF EMERGENCY PLEASE NOTIFY

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________

Phone: ______________________________

PROOF

Pharmacy: ______________________________ Location: ____________________________ Phone: ________________ Fax: ________________

I AM TAKING THE FOLLOWING MEDICATIONS:

We recommend using pencil so you can make changes to the list as your medications change.
Include over the counter and herbal products.

Drug Name	Strength	Dosage	How often/when	What is it for

HAVE THIS VERIFIED BY YOUR PHYSICIAN OR PHARMACIST EACH VISIT. **KEEP THIS CARD WITH YOU AT ALL TIMES.**

Medical Condition (Heart, Diabetes, etc.)

Allergies (Penicillin, Sulfa, Etc.)	**What happens when you take it** (briefly explain)

PROOF