LIST ALL MEDICINES YOU ARE CURRENTLY TAKING

Please list prescriptions and over-the-counter medications (ex: aspirin, antacids) and herbals (ex: ginseng, ginkgo). Make sure you include medications that you are taking routinely and "as needed."

Name of prescription, Over-the-counter medication, vitamins/supplements & dose	How Often You Take	Reason For Taking

Update this form whenever you have a change of medication or medical history.

Keep a copy of this form in your File of Life magnetic packet, which should be placed on your refrigerator. A copy of this form also should be kept in your wallet or purse in case of emergency. For additional copies of this form or to receive a new magnetic packet, please contact Triad coordinator at Albemarle County Sheriff's Office 434-972-4001. This form can also be obtained and filled out online at www.charlottesvilleAlbemarleTriad.org.

EMERGENCY MEDICAL INFORMATION

Charlottesville Albemarle Triad
www.CharlottesvilleAlbemarleTriad.org

(Use your computer to complete this section)

Date Updated:

Name:

Address:

Sex: Male / Female Date of Birth:

Primary Care Doctor:

Phone #:

Preferred Pharmacy:

Phone #:

Medical Insurance Co.:

Policy #:

Other Medical Insurance:

Policy #:

Medicare / Medicaid:

Policy #:

Living Will: Yes / No

Health Care Power of Attorney: Yes / No

EMERGENCY CONTACTS

Name: Phone #:

Address:

Name: Phone #:

Address:

MEDICAL DATA

Recent Surgeries/Hospitalizations: Date:

(over)

Tear on perforation and insert your updated File of Life form into your magnetic pocket.

MEDICAL CONDITIONS

(check all that apply)

HEART DISEASE	LUNG DISEASE	KIDNEY DISEASE
☐ CHF/Heart Failure	☐ COPD/Emphysema	☐ Failure
☐ High Blood Pressure	☐ Asthma	☐ Insufficiency
☐ Low Blood Pressure	☐ Fibrosis	☐ Dialysis
☐ High Cholesterol	☐ Pneumonia	☐ Kidney Stones
☐ Irregular Heart Beat	☐ Bronchitis	☐ Infections
☐ Pacemaker	☐ Shortness of Breath	
☐ Heart Attack	☐ Coughing	
☐ Angina or Chest Pain	☐ Lung Pain	
☐ Heart Surgery/ ByPass/Stent		

STOMACH DISEASE	NEUROLOGICAL DISEASE	MALIGNANCY/ CANCER
☐ Bowel Obstruction	☐ Stroke	☐ Lung
☐ Bleeding	☐ Bleeding in Brain	☐ Liver
☐ Diverticulitis	☐ Seizures	☐ Breast
☐ Hiatal Hernia	☐ Multiple Sclerosis	☐ Stomach
☐ GERD/Reflux	☐ Parkinson	☐ Leukemia
☐ Diarrhea	☐ Headaches	☐ Colon
☐ Blood in Stools	☐ Alzheimers or	☐ Skin
	☐ Memory Loss	☐ Other:

ENDOCRINE DISEASE	OTHER	
☐ Diabetes	☐ Arthritis	☐ Vision
Thyroid:	☐ Back Problem	☐ Problems
☐ High	☐ HIV	☐ Other
☐ Low	☐ Sickle Cell	
	☐ Weight Gain	
	☐ Weight Loss	

ALLERGIES

(check all that apply)

☐ Aspirin	☐ Laytex	☐ Tetracycline
☐ Barbiturates	☐ Lidocaine	☐ X-Ray Dye
☐ Codeine	☐ Morphine	☐ No Known Allergy
☐ Demerol	☐ Novocain	☐ Other:
☐ Insect Stings	☐ Penicillin	
☐ Horse Serum or	☐ Sulfa	
☐ Vaccines		

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UNIVERSAL MEDICATION FORM

(Use pencil on this form to allow for easy changing)

Date Updated: _____

Name: _____

Address: _____

Sex: Male / Female Date of Birth: _____

Primary Care Doctor: _____

Phone #: _____

Preferred Pharmacy: _____

Phone #: _____

Medical Insurance Co.: _____

Policy #: _____

Other Medical Insurance: _____

Policy #: _____

Medicare / Medicaid: _____

Policy #: _____

MEDICINE ALLERGIES/REACTIONS (describe reaction)

Drug:	Reaction: