



# HEALTH FACTS CARD

DATE LAST CHANGED: \_\_\_\_\_ (USE A PENCIL)

Take this card to all Doctor, Hospital  
and Pharmacy visits

For re-orders: [www.qchealthinitiative.org](http://www.qchealthinitiative.org)

Name: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

Date Of Birth: \_\_\_/\_\_\_/\_\_\_ Height: \_\_\_ Weight: \_\_\_\_\_

## EMERGENCY CONTACTS

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

Address: \_\_\_\_\_

Relation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Address: \_\_\_\_\_

Relation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## MEDICAL DATA

LAST UPDATED: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_

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

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

Hospital Preference: \_\_\_\_\_

Advance Directive: \_\_\_\_\_ Yes \_\_\_\_\_ No

On File at: \_\_\_\_\_

Recent Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

## IMMUNIZATIONS

Tetanus: \_\_\_/\_\_\_/\_\_\_ Pneumonia: \_\_\_/\_\_\_/\_\_\_

Influenza: \_\_\_/\_\_\_/\_\_\_ Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

## MEDICAL CONDITIONS

Check all that exist

- No known medical conditions
- Asthma
- Blood Disorder
- Cancer
- Cataracts
- COPD / Emphysema
- Coronary Bypass Graft
- Dementia
- Diabetes
- Glaucoma
- Heart Disease

- Hearing Impaired
- High Blood Pressure
- Kidney Failure
- Low Blood Sugar
- Pacemaker
- Seizure Disorder
- Sickle Cell Anemia
- Stroke
- Tuberculosis
- Vision Impaired
- Other Risk Factors

## ALLERGIES

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Aspirin                 | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Shellfish    |
| <input type="checkbox"/> Barbiturate             | <input type="checkbox"/> Latex         | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Codeine                 | <input type="checkbox"/> Lidocaine     | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Demerol                 | <input type="checkbox"/> Morphine      | <input type="checkbox"/> X-Rays Dyes  |
| <input type="checkbox"/> Tetanus                 | <input type="checkbox"/> Novocaine     | <input type="checkbox"/> Other        |
| <input type="checkbox"/> Environmental:<br>_____ | <input type="checkbox"/> Iodine        | _____                                 |
|  | <input type="checkbox"/> Penicillin    | <input type="checkbox"/> No Allergies |

MEDICATIONS ON REVERSE SIDE

