MEDICAL INFORMATION

Regina Sanchez
Spiritual Life & Health Coach
Revive Joy ✦ Rejuvenate Destiny ✦ Restore Health

FOR HOSPITAL REFERENCE. TAKE TO _____ HOSPITAL.

NAME: _____ **DOB:** _____

DNR (YES/NO): _____

POA/MEDICAL REP: _____

NAME: _____ **PHONE:** _____

EMERGENCY CONTACT INFO (IF DIFFERENT FROM POA/MEDICAL REP):

NAME: _____ **PHONE:** _____

MEDICATIONS/SUPPLEMENTS AS OF _____/_____/_____

PRESCRIPTIONS

Supplement	MG/IU/MCG	Dosage	Time of Day

NON-PRESCRIPTIONS

Supplement	MG/IU/MCG	Dosage	Time of Day

SERIOUS SIDE EFFECTS FROM:

MEDICAL CONDITIONS AS OF _____/_____/_____

ALLERGIES

SURGERIES

Year	Type

DENTAL WORK

Year	Type

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE: _____

MEDICARE (YES/NO):_____ ID: _____

ADDRESS: _____ PHONE: _____

SECONDARY INSURANCE: _____

ID: _____

ADDRESS: _____ PHONE: _____