



## About This Card

To provide you with the highest quality of medical care, it is important that every healthcare provider who treats you knows your health history and which medications, vitamins, patches, and over-the-counter products you take.

This form will help you organize this important health information. To use this form, please:

- Use a pencil and print clearly;
- Update this card regularly;
- Carry this card with you at all times; and
- Share this card with every healthcare provider who treats you.

Be sure to complete the back side of this sheet.

## About Me

NAME	( )	PHONE NUMBER	BIRTH DATE
ADDRESS			
CITY	STATE	ZIP	
1. EMERGENCY CONTACT NAME		( )	RELATIONSHIP
2. EMERGENCY CONTACT NAME		( )	RELATIONSHIP

## About My Doctors

PRIMARY CARE PHYSICIAN NAME	( )	PHONE NUMBER
PHYSICIAN NAME	SPECIALTY	( )
		PHONE NUMBER
PHYSICIAN NAME	SPECIALTY	( )
		PHONE NUMBER
PHYSICIAN NAME	SPECIALTY	( )
		PHONE NUMBER

## About My Medical History

SURGERY OR MEDICAL CONDITION	DATE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

## Signs of a Stroke

If you believe you or someone you know is having a stroke, call 911 immediately. Calling 911 quickly can make the difference in avoiding a lifelong disability. Look for:

- Sudden numbness or weakness of the face, arm or leg (especially on one side of the body)
- Sudden confusion, trouble speaking or understanding speech
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

Source: NINDS

## Signs of a Heart Attack

Many heart attacks start slowly as a mild pain or discomfort. Your symptoms may come and go. You should have all symptoms checked out. Look for:

- Chest discomfort like uncomfortable pressure, squeezing, fullness or pain
- Discomfort in the upper body, in one or both arms, the back, neck, jaw or stomach
- Shortness of breath
- Cold sweat, nausea or light-headedness

Carry a copy of your most recent EKG.

Source: NHLBI

## Key Phone Numbers for Suburban Hospital

Hospital Operator	301.896.3100	Medical Records	301.896.2570
Billing Office	301.896.6000	Patient Information	301.896.3118
Customer Relations	301.896.2000	Physician Referral	301.896.3939
Financial Counseling	301.896.2222	Support Groups	301.896.3939

## About Me

NAME

BIRTH DATE

BLOOD TYPE

( ) YES ( ) NO

ORGAN DONOR

( ) YES ( ) NO

ADVANCE DIRECTIVE

## My Vaccines

Please note the last date of each vaccine received.

FLU VACCINE

PNEUMONIA VACCINE

TETANUS VACCINE

## My Pharmacy

NAME

( )

PHONE

## About My Allergies

I am allergic to these medications / my reaction is:

1. \_\_\_\_\_ / \_\_\_\_\_
2. \_\_\_\_\_ / \_\_\_\_\_
3. \_\_\_\_\_ / \_\_\_\_\_
4. \_\_\_\_\_ / \_\_\_\_\_
5. \_\_\_\_\_ / \_\_\_\_\_
6. \_\_\_\_\_ / \_\_\_\_\_

I am allergic to these medications / my reaction is:

7. \_\_\_\_\_ / \_\_\_\_\_
8. \_\_\_\_\_ / \_\_\_\_\_
9. \_\_\_\_\_ / \_\_\_\_\_
10. \_\_\_\_\_ / \_\_\_\_\_
11. \_\_\_\_\_ / \_\_\_\_\_
12. \_\_\_\_\_ / \_\_\_\_\_

## About My Medications

List all medications you are currently taking, including all prescriptions, patches, herbals, vitamins, laxatives, and over-the-counter medications.

CURRENT MEDICATIONS	DOSAGE (how much you take)	FREQUENCY (how often you take it)	REASON (why you take this medication)
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			
7. _____			
8. _____			
9. _____			
10. _____			
11. _____			
12. _____			
13. _____			
14. _____			
15. _____			

