www.saintalphonsus.org

Medical Information Wallet Card

Carry with you at all times. Present to your health care provider.

My Name _____

Saint Alphonsus

367-2121

Ongoing Health Problems

Problem	Physician

Surgeries

Surgery	Year

Advanced Directives

Do you have a Living Will or Durable Power of Attorney for health care? ☐ Yes ☐ No

If you answered **yes**, who has a copy?

Name _____

Phone (_____)_____

Allergies

_____

_____

_____

Medications

Name	Dose (mg)	Per Day

Blood Pressure

Date	B/P	Date	B/P	Date	B/P
_____	___/___	_____	___/___	_____	___/___
_____	___/___	_____	___/___	_____	___/___

Do You Take Any of the Following

Aspirin ☐ Yes ☐ No **Inhalers** ☐ Yes ☐ No

Advil ☐ Yes ☐ No **Eye Drops** ☐ Yes ☐ No

Herbals ☐ Yes ☐ No **Supplements** ☐ Yes ☐ No

Emergency Contact

Name _____

Address _____

Phone (_____) _____