Vital Medical Information

Name: Date Completed:

Date of Birth: Gender:

Address:

City: State: Zip:

Phone:

Emergency Contacts

Name: Phone:

Name: Phone:

Pet Care: Phone:

Doctors

Name: Phone:

Name: Phone:

Dentist: Phone:

Preferred Hospital: Phone:

Vaccines

☐ Flu ☐ COVID 19 Brand: _____

☐ Pneumococcal ☐ Shingles

☐ Tetanus/Pertussis

Drug or Other Allergies

Medications

	Dose:	How often:
	Dose:	How often:
	Dose:	How often:
	Dose:	How often:
Over the Counter:	Dose:	How often:
Vitamins/Supplements:	Dose:	How often:

Advance Directives

☐ Living Will ☐ Durable Power of Attorney ☐ Long-Term Care Insurance Policy

Place where kept:

Important Medical History