**Health and Medication List** **Stony Brook University Medical Center**

Pease keep a copy for emergencies and bring a copy to all healthcare visits

Date last updated:_____

**Patient Information**

Name:_____

Address:_____

_____

Date of Birth:_____Blood Type:_____

Height:_____Weight:_____

**Medical Conditions:**

___ Asthma
___ Heart Disease
___ Diabetes
___ High Blood Pressure
___ Kidney Disease
___ Other_____

Emergency Contact:_____ Phone:_____

Physician:_____ Phone:_____

Pharmacy:_____ Phone:_____

**Date of last Vaccine:**

_____Tetanus _____Pneumococcal _____Influenza _____Hepatitis

**Medication/Food/Environmental Allergy:** **Effect/Reaction:**

___Check if none

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a latex allergy? _____ Yes _____ No

**Prescription Medications**

___Check if none

| Name | Dosage | How often | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Over-the Counter Medications**

___ Check if none

**Herbs, Vitamins, Minerals**

___ Check if none

**(Continue medications on page 2, if needed)**

***** Tell your health care provider if you are pregnant or breastfeeding.



**Prescription Medications**

| Name | Dosage | How often | Reason for taking |
|---|---|---|---|
| | | | |
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**Over-the Counter Medications**

**Herbs, Vitamins, Minerals**