Conditions I am being treated for:

1.
2.
3.
4.
5.

Medication Allergies & Sensitivities

Medication	Type of Reaction	Date of Reaction

Name:

Address:

Phone Number:

Date of Birth:

Height: Weight:

Doctor's Name and Phone Number:

Pharmacy Name and Phone Number:

Emergency Contact Name and Number:

Congratulations on taking the first step towards improving the quality of your healthcare. Completing this card, keeping it updated and with you at all times will help ensure that your healthcare providers can offer better treatment.

For additional copies of this card call 201-291-6330 or visit www.valleyhealth.com

Personal Medication Card

The Valley Hospital
Valley Health System

Prescription medications, supplements or vitamins I am taking regularly or as needed.

(Cross out if discontinued)

Start Date	Medication Name/Strength	Pills/Dose	Time/Day
9/23/06	*Lipitor, 10mg*	*1 pill*	*mornings/daily*

Immunizations

Date of last flu vaccine:

Date of last Pneumovax:

Date of last Tetanus: