<table>
<thead>
<tr>
<th>Date started</th>
<th>Name of medicine</th>
<th>Dose (mg, unit, puffs, drops)</th>
<th>Route (by mouth, eye drops)</th>
<th>Directions</th>
<th>Purpose (Why do you take it?)</th>
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**Medications:** Please list all prescription and non-prescription medications, herbals, nutritional supplements, eye drops, inhalers, etc., that you use. Cross out medicine name if no longer taking.

**Diabetic patients**

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<tr>
<th></th>
<th>Date:</th>
<th>Level:</th>
<th>Date:</th>
<th>Level:</th>
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<tbody>
<tr>
<td>HbA1c, every 6 months, goal = &lt; 8.0</td>
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<td>LDL, annually, goal = &lt; 100</td>
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<td>Urine albumin, annually</td>
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<td>Foot check (monofilament), annually</td>
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</table>
My medical information

Primary care clinic:
Provider:
Clinic phone:

Your name:
Date of birth:
Phone:

Emergency contact
Name:
Phone:

Allergies
List medications, foods, iodine, tape, etc.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Reaction</th>
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Pharmacy:
Phone:

Vaccine history
- Tetanus/Tdap [ ] date:
- Pneumovax [ ] date:
- Influenza (flu) [ ] date:
- Hepatitis A/B [ ] date:
- Zostavax [ ] date:
- [ ] date:
- [ ] date:

Procedures/imaging studies
- Colonoscopy [ ] date:
- DEXA scan [ ] date:
- [ ] date:
- [ ] date:

Lab tests
- Cholesterol [ ] date:
- [ ] date:
- [ ] date:
- [ ] date:
- [ ] date:

Dentist
Provider:
Phone:

Last Exam:
Next Exam:

Physical exam

Last exam:
Blood pressure: /
Weight: lbs
Next exam:

Eye exam (annually if diabetic)
Provider:
Phone:
Last exam:
Next exam:

Dermatology — mole checks
Provider:
Phone:
Last exam:
Next exam:

Pap (women) or PSA (men)
Facility:
Phone:
Last exam:
Next exam:

Mammogram (women)
Provider:
Phone:
Last exam:
Next exam: