

## Chronological Essential Health Information

This form provides your medical provider with an instant overview of lifetime medical events and other essential information when time is of the essence. **Be sure to print this out and have it in your possession for emergency personnel.**

Update this form whenever information changes and have a copy in your wallet, purse and glove compartment in your vehicle.

*Use multiple copies of any page in this form if more space is needed.*

**Family Member:**

Date of  
Birth:

Blood  
Type:

Gender:

Date:      Medical Event (i.e., Tonsillectomy, Measles, Appendectomy, etc.)      Brief Description (Who, What, When, Where, Why)

**Medication Information**

**Family Member:**

Date of  
Birth:

Blood  
Type:

Gender:

**Name of Medication:**

**Dosage & Frequency:**  
(i.e., 5 mg total every AM)

Reason for Medication:

Name & Contact  
Information of Physician:

**Name of Medication:**

**Dosage & Frequency:**  
(i.e., 5 mg total every AM)

Reason for Medication:

Name & Contact  
Information of Physician:

**Name of Medication:**

**Dosage & Frequency:**  
(i.e., 5 mg total every AM)

Reason for Medication:

Name & Contact  
Information of Physician:

**Name of Medication:**

**Dosage & Frequency:**  
(i.e., 5 mg total every AM)

Reason for Medication:

Name & Contact  
Information of Physician:

**Name of Medication:**

**Dosage & Frequency:**  
(i.e., 5 mg total every AM)

Reason for Medication:

Name & Contact  
Information of Physician:

Family Member Additional Information

**Family Member:**

Date of  
Birth:

Blood  
Type:

Gender:

**Allergies**

Medication Allergies

Food Allergies

Additional Allergies

**Medical Insurance**

Insurance Co Name (primary):

Member Name:

Member #:

HMO/PPO/  
Medicare:

Group#:

Insurance Co Name (secondary):

Member Name:

Member #:

HMO/PPO/  
Medicare:

Group#:

