

Template: My Medical List

My Name: _____

Date of Birth: _____

Medicare Number: _____

My Doctor's Name: _____

Doctor's Phone Number: _____

Who to Call in an Emergency

Name: _____

Phone Number: _____

Relationship to me (e.g., Son, Friend): _____

My Future Care Wishes

Do I have an Advance Care Directive? (Circle one) Yes / No

If yes, where is it kept? _____

My Medicines

(List all medicines, including vitamins and puffers)

Medicine Name	How Much I Take (Dose)	When I Take It	Why I Take It

My Allergies or Bad Reactions

(List anything that makes you sick, like medicines, food, or bee stings)

What I am Allergic To	What Happens (e.g., Rash, Swelling)

My Health Problems

(List any health problems or big operations you have had)

- _____
- _____
- _____
- _____

Date I last checked this list: _____

Disclaimer: This template is for informational purposes only and does not constitute professional advice. We do not guarantee the accuracy or reliability of its information or calculations.

Your use of this tool is at your own risk, and we are not responsible for any resulting loss or damage. This tool does not consider your personal situation, so you must consult a qualified professional for advice tailored to your needs.