HEALTH CARE CARD

Name ______________________________

Address ______________________________

Phone ______________________________

Please Keep With You At All Times.
Update This Card At Each Doctor's Visit.

THE University of Vermont HEALTH NETWORK
Central Vermont Medical Center

ALLERGIES: ______________________________

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Inoculations	Date
__ Herpes Zastavax	____________
__ Hepatitis B	____________
__ Tetanus/Diptheria	____________
__ Pertussis	____________
__ Flu Shot	____________
__ Pneumovax	____________
__ MMR	____________

In case of emergency notify:

Dr: ______________________________

(phone) ______________________________

Contact: (name) ______________________________

(phone) ______________________________

Date of Birth ______________________________

Medical Problems/Conditions:

__ Asthma __ Lung Disease

__ Heart Disease __ High Blood Pressure

__ Kidney Disease __ MRSA/VRE

__ Diabetes HgAIC ______________________________

__ Others ______________________________

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Implantable Devices: **Yes** **No**

Where ______________________________

When ______________________________

Surgeries: ______________________________

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MEDICATION	DOSE	TIME

Medication Patch: Type ____________ Time On ________ Time Off ________

Dose ____________

Other Supplements:	DOSE	TIME
___ Antacids		
___ Vitamins/Minerals		
___ Iron Tablets		
___ Laxatives		
___ Herbal/Dietary Supplements		
___ St. John's Wort		
___ Ginkgo Biloba		
___ Vitamin E		
___ Garlic Pills		

Notes: ____________