iCare

Patient Advocate

HEALTH AT-A-GLANCE

PATIENT
NAME _____
DATE _____

EMERGENCY CONTACT
NAME _____
PHONE _____

ALLERGIES	MEDICATION

VACCINES	DATE OF LAST

DISSABILITIES OR IMPAIRMENTS	MEDICATION	EQUIPMENT/DEVICES

MAYOR ILLNESSES	MEDICATION	DATE IT STARTED

MEDICAL PROCEDURES	DATE

HOSPITALIZATONS	DATE

MEDICATIONS	DRUGS (PRESCIPTION & OVER THE COUNTER)	VITAMINS & HERBALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has there been any medication interaction

_____

_____

SPECIALIST/RELATED CONDITION	NAME	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY CONDITIONS

_____

_____

ADITIONAL INFORMATION

DO YOU HAVE LIVING WILL YES _____ NO _____

DO YOU HAVE POWER OF ATTORNEY YES _____ NO _____

ARE YOU AN ORGAN DONOR YES _____ NO _____

CONTACT PERSON _____

PHONE _____