**Full Name Medications List** (as of *date*)

Address: Phone: Email:

Emergency Contacts: (*relationship, name, phone*)

Birthdate: Family doctor: (*name, location, phone #)*  
BC Care # Specialists:   
Extended Health # (*specialty,* *name, location, phone #)*  
Travel Policy: (*company*) #

Family history of health issues: *(e.g. cancer, heart, high/low blood pressure, diabetes, Alzheimer’s, etc.)*  
Health habits: non-smoker or smoker *(#/day, start date, quit date*)   
Alcohol: *# drinks*/week. Drug use: *(specify/frequency)*

**Medical Condition: Medication , dosage, prescribed by\_\_ , since *date***

Examples:

High blood pressure (dx 2010) **Perindopril** 4mg ¼ day (Dr. Jones), since 2016

**~~Amlodipine~~** ~~2.5mg ½ day (Dr. Black)~~ stopped Jan 4/22

Concussions 2010, 2014 (ER), 2018 (CT)

Sleep apnea Bi-PAP machine (Vitalaire) since 2010  
  
Sleep difficulties **Zopiclone** 7.5 mg, as needed   
 Melatonin – as needed  
  
Tinnitus (WCB) hearing aids since 2017

**Vitamins, minerals, etc.**

Glaucoma (mild, detected 2010) Vitalux – Lutien 10 mg, 2/day, (Dr. Blue)

Muscle pain Magnesium – 150 mg, 1/day

**Immunizations:** (item/date)

- Shingrix –

- Tetanus –

- Pneumovax –

- Flu shot annually –

- Covid -

**Medication issues:** (reactions, allergies)

* Medication / issues

**Surgeries:**

Year / surgery for / outcome or issues