# Health At A Glance

**Name** _____ **Date of Birth** _____

**ALLERGIES/REACTIONS**

**MEDICAL CONDITIONS (PROBLEMS)**

**CURRENT MEDICATIONS, SUPPLEMENTS, VITAMINS, HERBS. TAKEN DAILY AND OCCASIONALLY**

| Medication Name | Dosage | Frequency Taking | Reason for Taking: |
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**DATES OF LAST IMMUNIZATIONS**

Tetanus/Diphtheria _____ COVID-19 _____

Pneumonia Flu _____

Shingles

**FAMILY DOCTOR**

Name: _____ Phone Number: _____

Address: _____

Primary Physician

**EMERGENCY CONTACT**

Name: _____ Relationship _____

Phone Number

Living Will Yes ☐ No ☐

Durable Power of Attorney: Phone Number:

INTERNATIONAL AUTOIMMUNE ENCEPHALITIS SOCIETY