BEFORE YOU START

My health card

NAME	
DATE OF BIRTH	
DOCTOR, PHONE	
PHARMACY, PHONE	
OTHER SPECIALISTS	
EMERGENCY CONTACT	
EMERGENCY NUMBER WHERE I LIVE	
POISON CENTER WHERE I LIVE	

ALLERGIES AND REACTIONS TO MEDICINES OR SUPPLEMENTS

CONDITIONS I'M BEING TREATED FOR

SURGERY THAT MATTERS FOR NUTRIENTS (STOMACH, BOWEL, WEIGHT-LOSS SURGERY)

MY DIET, IN A LINE (VEGAN, LITTLE FISH, EAT LESS THAN I USED TO…)

☐ Pregnant or planning ☐ I smoke ☐ Young children at home ☐ On a blood thinner

NOTES

Everything else I take

Over-the-counter medicines, vitamins, minerals, herbs, powders, medicinal teas, “seasonal” pills, and things you take only now and then. Copy the doses from the ingredient panel on the back of each bottle, not the front.

PRODUCT	MAIN INGREDIENTS AND DOSE	HOW OFTEN	SINCE	WHO SUGGESTED IT	WHAT IT'S FOR

NOTES