NAME:

Address

Date of Birth Weight

Primary Insurance ID # Insurance Phone

Secondary Insurance ID # Insurance Phone

Emergency Contact

Phone Relationship

Primary Healthcare Provider Phone

**ALL MEDICATIONS (PRESCRIPTION & OTC)**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th># of Tabs/Caps</th>
<th># of Times Per Day</th>
<th>Reason for Taking</th>
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stepsforliving.hemophilia.org

Steps for Living is an education program that was created in part through the Centers for Disease Control and Prevention (CDC) Cooperative Agreement with continued support from Pfizer Hemophilia. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.
NAME: ____________________________

Allergies: ____________________________

Past Surgeries: ____________________________

Last Tetanus: ____________________________

Other Medical Conditions: ____________________________

Medications to Avoid & Reason: ____________________________

Bleeding Disorder (type/severity): ____________________________

Clotting Factor Affected: ____________________________

Hematologist/Hemophilia Treatment Center: ____________________________

Phone: ____________________________

Preferred ER: ____________________________

Past Bleeds: ____________________________

Self/Home-infusion? □ YES □ NO

Type & Location of port/PICC: ____________________________

Possible Alternative Factor Medication: ____________________________

NOTES: ____________________________