



# MY MEDICATION RECORD

## Immunization Record (date/year and last dose)

Tetanus: \_\_\_\_\_

Flu vaccine: \_\_\_\_\_

Pneumonia vaccine: \_\_\_\_\_

Hepatitis vaccine: \_\_\_\_\_

## My Medical Conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HOW TO USE THIS FORM

- ALWAYS keep this form with you in your purse or wallet so it is available in case of an emergency.
- Take this form to all doctor visits and hospital visits.
- WRITE DOWN ALL CHANGES made to your medications.
- If a medication is stopped, draw a line through it and write the date it was stopped.
- When you are discharged from the hospital, the nurse will go over your new medication list and give you a copy. Please use this list to complete a new medication record. The nurse can give you a clean copy if needed.

Last updated:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Formed: 9/24/2013

# MY MEDICATION RECORD

## My Personal Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Primary Care Physician

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Pharmacy

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Other Physicians

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## My Allergies and Drugs to Avoid

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Reactions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

