

Personal Medication Information

Fold this form & keep it in your wallet. It will help you:

- Reduce confusion and save time
- Improve communication
- Improve medical safety

Always keep this form (or an updated version) with you, and take an updated list with you to all doctor visits, all medical tests and all procedures. Update your list as changes are made to your medications.

When you are discharged from the hospital some of your medications may have been changed. These changes will be reviewed with you.

Pharmacy Name and Phone Number: _____

Your Name	Address
Birth Date	
Phone Number	

Allergic To	Describe Reaction

Immunization Record	
Please tick <input checked="" type="checkbox"/> if you have had the following vaccines and write the date, if possible.	
Vaccine	Date
<input type="checkbox"/> Flu	
<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Hepatitis	

List all prescription medications **that you are currently taking** and over-the-counter (non-prescription) medications, such as vitamins, Aspirin, Tylenol and herbals (such as Ginseng, Gingko Biloba, and St. John 's Wort).

Name of Medication	Dose	When Taken	Reason for Taking

