MY MEDICATION RECORD

side 2

Name: ______________________ **Birth date:** ____________ **Phone:** ______________

Always carry your medication record with you and show it to all your doctors, pharmacists and other healthcare providers.

Emergency Contact Information
Name
Relationship
Phone Number
Primary Care Physician
Name
Phone Number
Pharmacy/Pharmacist
Name
Phone Number

Allergies	
What allergies do I have? (Medicines, food, other)	What happened when I had the allergy or reaction?

Other Medicine Problems	
Name of medicine that caused problem	What was the problem I had with the medicine?

When you are prescribed a new drug, ask your doctor or pharmacist:
• What am I taking?
• What is it for?
• When do I take it?
• Are there any side effects?
• Are there any special instructions?
• What if I miss a dose?

Notes:

Patient's Signature	Healthcare Provider's Signature	Date last updated	
		Date last reviewed by healthcare provider	

08-029

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MY MEDICATION RECORD

side 1

LOGO

Name:______________________________ **Birth date:** ____________________

Include all of your medications on this record: prescription medications, nonprescription medications, herbal products, and other dietary supplements.
Always carry your medication record with you and show it to all your doctors, pharmacists and other healthcare providers.

Drug		Take for...	When do I take it?				Start Date	Stop Date	Doctor	Special Instructions
Name	Dose		Morning	Noon	Evening	Bedtime				

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