

MY MEDICATION RECORD

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 Physician

Name
Phone
Last Visit

Other Physician

Name
Phone
Last Visit

Pharmacy/Pharmacist

Name	Phone Number
------	--------------

Allergies

What allergies do I have? <i>(medicines, food, other)</i>	What happened when I had the allergy or reaction?

Side Effects to Medication

Name of medicine that caused problem.	What was the problem I had with the medicine?

Health Problems

Questions to Ask When Prescribed a New Drug

✓ What am I taking?	✓ Are there any side effects?
✓ What is it for?	✓ Are there any special instructions?
✓ When do I take it?	✓ What if I miss a dose?

Notes:

<i>Patient's Signature</i>	<i>Healthcare Provider's Signature</i>	Date last updated:
		Date last reviewed by healthcare provider:

