

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 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