My Medication Card

Name:_____

Address:_____

_____

_____

_____

Phone:_____

(Please fold on line)

Physician, Pharmacy and Emergency Contacts

Physician:_____

Phone:_____

Pharmacy:_____

Phone:_____

Emergency Contact:_____

_____

Phone:_____

(Please fold on line)

Immunization Record

(Record the date and year of last dose taken, if known)

Tetanus:_____

Flu Vaccine (s):_____

Other:_____

Pneumonia Vaccine:_____

_____

Hepatitis:_____

Other:_____

(Please fold on line)

Allergies

Allergic to:_____

Reaction:_____

Allergic to:_____

Reaction:_____

Allergic to:_____

Reaction:_____

Allergic to:_____

Reaction:_____

Allergic to:_____

Reaction:_____

Medical History

Please check those that apply:

- ❑ Asthma
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Kidney Disease
- ❑ Cancer
- ❑ High Blood Pressure

Other:_____

Over-the-Counter Medications

Check those you use regularly:

- ❑ Allergy relief, Antihistamines
- ❑ Antacids
- ❑ Aspirin/Tylenol/Ibuprofen
- ❑ Cold/Cough Medicines
- ❑ Diet Pills
- ❑ Herbals. dietary supplements
- ❑ Laxatives
- ❑ Sleeping Pills
- ❑ Vitamins or Minerals
- ❑ Other:_____

My Medication Card

is made possible with the support from:

Whenever you see a doctor, including your primary care physician, specialist or emergency room physician, review and update this medication list.

Date started	**Name of Medicine** Brand name, generic name or over-the-counter drugs	**Dose** mg, units, puffs, drops	**When do you take it?** How many times per day? Morning and night? After meals?	**Purpose** Why do you take it?

Name:_____**Emergency Contact:**_____**Phone:**_____