My Medication Card

Name:________________

Address:______________

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____

____

Phone:_______________

Physician, Pharmacy and Emergency Contacts

Physician:______________

Phone:________________

Pharmacy:_____________

Phone:________________

Emergency Contact:_______

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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)

(Please fold on line)

Allergies

Allergic to:______________

Reason:________________

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:**____________________