

PERSONAL MEDICATION FORM

PATIENT IDENTIFICATION

Name: _____ Date of birth: _____ Date form last updated: _____

Your complete medication history is important to your physicians and to the hospital. Please fill out this form and bring it with you anytime you go to the doctor's office or to the hospital.

If for some reason you are unable to fill out this form, please bring in a bag of all of the medications (in their original containers) that you are currently taking.

Medications: Please list **all** prescription and non-prescription medications, herbals, eye drops, nutritional supplements, inhalers, etc that you use.

Write additional medications on back if needed.

NAME OF MEDICINE	DOSE (Mg, units, puffs)	ROUTE (By mouth, eye drops)	DIRECTIONS	PURPOSE Why do you take it?

Allergies: Are you allergic to medications, iodine, food, tape, or latex?
List each substance you are allergic to and the reaction you experienced.

SUBSTANCE	REACTION	SUBSTANCE	REACTION

Vaccine / Immunization: Check one box for each vaccine.

PNEUMONIA	INFLUENZA (FLU)	TETANUS	PEDIATRIC (FOR CHILD)
<input type="checkbox"/> Previous vaccination Within past 5 years <input type="checkbox"/> Vaccinated at 65 or older <input type="checkbox"/> Unknown	<input type="checkbox"/> Vaccinated this year <input type="checkbox"/> Unknown <input type="checkbox"/> If under 13 vaccinated	<input type="checkbox"/> Date last given: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Up-to-date <input type="checkbox"/> Unknown

Contact Information:

Doctor's Name: _____ Dr. Phone: (_____) _____
 Pharmacy Name: _____ Pharmacy Phone: (_____) _____
 Emergency Contact Name: _____ Phone: (_____) _____