

# MEDICATION LIST FORM

Date Form Started: \_\_\_\_\_

<b>Name:</b>	<b>Address:</b>
<b>Phone #:</b>	
<b>Birth Date:</b>	<b>PHN #:</b>
<b>Emergency Contact / Phone #:</b>	

IMMUNIZATION RECORD		
(Record the date/year of last dose taken, if known.)		
TETANUS:	FLU VACCINE(S):	
PNEUMONIA VACCINE:	HEPATITIS VACCINE:	OTHER:

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:

**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:**

Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo).  
Include medications taken as needed (example: Nitroglycerin).

MEDICATION / DOSE (Example: Simvastatin 200 mg)	DIRECTIONS How much I take / When I take it. (Example: one tablet at bedtime)	REASON FOR TAKING (Example: Cholesterol)	DOCTOR'S / PRESCRIBER'S NAME