

MEDICATION LIST FORM

Fold this form and keep it in your wallet.

Date Form Started: _____

Name:	Address:
Phone #:	
Birth Date:	PHN #:
Emergency Contact / Phone #:	

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