

MY MEDICATION RECORD

Name: _____ Birth date: _____ Phone: _____

Always carry your medication record with you and show it to all your doctors, pharmacists and other healthcare providers.

Emergency Contact Information

Name

Relationship

Phone Number

Primary Care Physician

Name

Phone Number

Pharmacy/Pharmacist

Name

Phone Number

Allergies

What allergies do I have? (Medicines, food, other)

What happened when I had the allergy or reaction?

Other Medicine Problems

Name of medicine that caused problem

What was the problem I had with the medicine?

When you are prescribed a new drug, ask your doctor or pharmacist:

•What am I taking?

•What is it for?

•When do I take it?

•Are there any side effects?

•Are there any special instructions?

•What if I miss a dose?

Notes:

Patient's Signature

Healthcare Provider's Signature

Date last updated

Date last reviewed by
healthcare provider