

# MY MEDICATION RECORD

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_



Always carry your medication record with you and show it to all your doctors, pharmacist, and other healthcare providers. Include all of your medications on this record: prescription and over the counter medications, including herbal products and other dietary supplements.

<b>Emergency contact information</b>	
<i>Name</i>	<i>Relationship</i>
	<i>Phone</i>
<b>Primary Care Physician:</b>	<i>Phone</i>
<b>Pharmacy/Pharmacist:</b>	<i>Phone</i>
<b>Allergies</b>	
<i>Allergies that I have (medicines, food, other).</i>	<i>What happened when I had the allergy or reaction?</i>
<b>Other medicine problems</b>	
<i>Name of medicine that caused problem.</i>	<i>The problem I had with this medicine.</i>

Drug		Take for...	When do I take it?				Start date	Stop date	Doctor	Special instructions
Name	Dose		Morn- ing	Noon	Eve- ning	Bed- time				
<i>Example: Glyburide</i>	<i>5mg</i>	<i>diabetes</i>	<i>1</i>		<i>1</i>		<i>1/1/08</i>		<i>Johnson</i>	<i>with food</i>

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