My Medication List

Your healthcare providers at Harney District Hospital ask you to be an active member of your healthcare team. Please keep your medication list up to date and with you at all times.

My Name:____Date List Updated:__________________

My Pharmacy Name:____________________________Pharmacy Phone:______________________

My Birthdate:________________________My Phone Number:______________________________

Emergency Contact/Phone:____

My Allergies and Drugs to Avoid/Adverse Reactions:

____

____

Current Medications: *List <u>all</u> medications you are taking; include over-the-counter preparations (like aspirin, pain relievers, antacids, vitamins, herbals)*

Medication:____Dosage:________________________
Reason for taking:____________________________Directions:__________________________
Doctor:____Date started:____________________

Medication:____Dosage:________________________
Reason for taking:____________________________Directions:__________________________
Doctor:____Date started:____________________

Medication:____Dosage:________________________
Reason for taking:____________________________Directions:__________________________
Doctor:____Date started:____________________

Medication:____Dosage:________________________
Reason for taking:____________________________Directions:__________________________
Doctor:____Date started:____________________

Medication:____Dosage:________________________
Reason for taking:____________________________Directions:__________________________
Doctor:____Date started:____________________

Current Medications: (continued)

Medication:______________________________Dosage:__________________
Reason for taking:____________________Directions:____________________
Doctor:________________________________Date started:_______________

Medication:______________________________Dosage:__________________
Reason for taking:____________________Directions:____________________
Doctor:________________________________Date started:_______________

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Reason for taking:____________________Directions:____________________
Doctor:________________________________Date started:_______________

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Reason for taking:____________________Directions:____________________
Doctor:________________________________Date started:_______________

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Reason for taking:____________________Directions:____________________
Doctor:________________________________Date started:_______________

Immunization Record: (include dates administered)

☐ Tetanus____________________ ☐ Pneumonia Vaccine____________________
☐ Flu Vaccine ____________________ ☐ Other______________________________