

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	