Whenever you see a doctor, including your primary care physician and any specialist, **review and update this medication list.**
After any hospitalization, check with your doctor to review this medication list.

NAME OF DRUG	DATE (Added or changed)	STRENGTH/ DOSE	HOW MANY TIMES A DAY IT IS TAKEN	REASON FOR TAKING

Include Prescribed, Over the Counter, Vitamins and Herbal Medications

Allergies Drug/Food/ Latex	Reaction

NAME: _____

ADDRESS: _____

_____

_____

PHONE: _____

BIRTH DATE: _____

FAMILY DOCTOR: _____

PHONE: _____

Pharmacy: _____

Phone: _____

Pharmacy: _____

Phone: _____

IN EMERGENCY CALL:

NAME: _____

PHONE: _____

Immunization:

VACCINES	DATES GIVEN				
FLU					
PNEUMONIA					
TETANUS					

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