My Medication Record

Name: _____ Birth Date: _____ Phone: _____

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

Emergency Contact Information	
Name:	
Relationship:	
Phone Number:	
Primary Care Physician	
Name	
Phone Number	
Allergies	
What allergies do I have? (meds, food, other)	What happened/ happens when I have a reaction?
What other Medicine Problems do I have?	
Name of medication that caused the problem	What caused the problem that I had with the medication?
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 special instructions?	
• What if I miss a dose?	
Notes	

Patient Signature: _____ Healthcare Provider's Signature: _____

Date last updated: _____ Date last reviewed by healthcare provider: _____