Patient Tools

Personal Medication Information

Fold this form & keep it in your wallet

How does using this form help you?

- ✔ Reduces confusion and saves time
- ✔ Improves communication
- ✔ Improves medical safety

- Always keep this form (or an updated version) with you.
- Take an updated list to all doctor visits and all medical tests and or procedures.
- Update your list as changes are made to your medications.
- When you are discharged from the hospital some of your medications may have been changed. These changes will be reviewed with you.

Pharmacy Name and Phone Number: _____

Your Name:	**Address:**
Birth Date:	
Phone #:	

Allergic to	**Describe reaction**

Immunization Record

Please tick ☑ if you have had the following vaccines and write the date, if possible.

Vaccine:	**Date:**
☐ Flu	
☐ Pneumonia	
☐ Tetanus	
☐ Hepatitis	

List all prescription medications **that you are currently taking** & over-the-counter (non-prescription) medications, such as vitamins, aspirin, Tylenol® & herbals (such as ginseng, gingko biloba, and St. John 's wort). Include prescription medications taken as needed (such as nitroglycerin, Viagra®).

Name of Medication	Dose	When Taken	Reason for Taking