

**My Medication Card**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

**Physician, Pharmacy  
and Emergency Contacts**

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

(Please fold on line)

**Immunization Record**

(Record the date and year  
of last dose taken, if known)

Tetanus: \_\_\_\_\_

Flu Vaccine (s): \_\_\_\_\_

Other: \_\_\_\_\_

Pneumonia Vaccine: \_\_\_\_\_

\_\_\_\_\_

Hepatitis: \_\_\_\_\_

Other: \_\_\_\_\_



(Please fold on line)

(Please fold on line)

**Allergies**

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

**Medical History**

Please check those that apply:

- Asthma       Heart Disease
- Diabetes     Kidney Disease
- Cancer       High Blood Pressure

Other: \_\_\_\_\_

**Over-the-Counter Medications**

Check those you use regularly:

- Allergy relief, Antihistamines
- Antacids
- Aspirin/Tylenol/Ibuprofen
- Cold/Cough Medicines
- Diet Pills
- Herbals, dietary supplements
- Laxatives
- Sleeping Pills
- Vitamins or Minerals
- Other: \_\_\_\_\_



**My Medication Card**

is made possible with  
the support from:



**Whenever you see a doctor, including your primary care physician, specialist or emergency room physician, review and update this medication list.**

<b><u>Date started</u></b>	<b><u>Name of Medicine</u></b> Brand name, generic name or over-the-counter drugs	<b><u>Dose</u></b> mg, units, puffs, drops	<b><u>When do you take it?</u></b> How many times per day? Morning and night? After meals?	<b><u>Purpose</u></b> Why do you take it?



**Name: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_**