

Personal Medication Record

(Always keep this form with you. Take this record with you to every doctor and hospital visit.

Update your list after every doctor and hospital visit)

Nan	10	Date of Birth	Date of Record		

Allergies and Reactions (please describe what happened when you took medicine)				
Medication	Reaction			



Doctor / Dentist / Prescriber's Name	Phone Number	Type of Practitioner/Reason for Seeing

Pharmacy Name	Phone Number	Location



LIST OF CURRENT MEDICATIONS:

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include all prescriptions, over the counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (such as Viagra, nitroglycerin).

Print as many copies of this page as needed to list all medications.

Medication (Brand and Generic Name)	Dose	How you take the medicine & how often you take the medicine	Reason for taking medicine	Date Started	Date Stopped (Mark "NA" if still taking)	Doctor Name