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MEDICATION LIST

NAME | DATE OF BIRTH | PHONE | LIST UPDATED ON

EMERGENCY CONTACT (NAME, RELATIONSHIP, PHONE)

HEALTH INSURANCE AND MEMBER ID

HEALTH CONDITIONS

OTHER (IMPLANTS, PACEMAKER, BLOOD TYPE, ORGAN DONOR)

Allergies and bad reactions

Allergic to	Reaction (and year)

Doctors

Doctor	Specialty	Phone

PHARMACY, ADDRESS AND PHONE

MAIL-ORDER OR SECOND PHARMACY

Medicines I take now (prescription, over the counter, vitamins and supplements)

Medicine and strength	Dose	How often / when	What it is for	Rx / OTC	Prescriber	Started	Notes

Medicines I stopped

Medicine and strength	Stopped on	Why (side effect, switched, no longer needed) and who said so

Bring this list to every appointment, the pharmacy and the hospital. Update it each time a medicine is started, stopped or changed, and ask your doctor or pharmacist to check it. This list is a record only and is not medical advice.