

# MY MEDICATION RECORD

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

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

## Emergency Contact Information

Name	
Relationship	Phone Number

Primary Physician
Name
Phone
Last Visit

Other Physician
Name
Phone
Last Visit

Pharmacy/ Pharmacist
Name
Phone Number

Allergies	
What allergies do I have? (medicines, food, other)	What happened when I had the allergy or reaction?

Side Effects to Medication	
Name of medicine that caused problem.	What was the problem I had with the medicine?

Health Problems

Questions to Ask When Prescribed a new Drug	
√ What am I taking?	√ Are there any side effects?
√ What is it for?	√ Are there any special instructions?
√ When do I take it?	√ What if I miss a dose?

Notes:		
<i>Patient's Signature</i>	<i>Healthcare Provider's Signature</i>	Date last updated: Date last reviewed by healthcare provider:

# MY MEDICATION RECORD

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

Include all of your medications on this record: prescription medications, non-prescription medications, herbal products, and all other dietary supplements.

Drug		Take for (reason)	When Do I Take It?				Exp. Date*	Doctor	Special Instructions
Name	Dose		AM	Noon	PM	Bed-time			

This sample Personal Medication Record (PMR), while intended to serve as a communication aid between patient (or other use) and healthcare provider, is not a substitute for obtaining professional healthcare advice or treatment. Under no circumstances should medication be changed or stopped without consulting a doctor.

\*Exp. Date = Expiration date of medication