MY MEDICINE LIST

Name:	D.O.B:	Allergic To: *(Describe reaction)*
Emergency Contact/Phone numbers:		
Doctor(s):		
Pharmacies, other sources:		

Immunization Record *(Record the date/year of last dose taken)*		Flu vaccine(s):	
Pneumonia vaccine:	Tetanus:	Hepatitis vaccine:	Other:

List all medicines you are currently taking. Include prescriptions (examples: pills, inhalers, creams, shots), over-the-counter medications (examples: aspirin, antacids, vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin, inhalers).

START DATE	NAME OF MEDICATION DOSE	DOSE	DIRECTIONS *(How do you take it? When? How Often?)*	DATE STOPPED	GOALS *(Reason for taking?)*