PERSONAL MEDICATION FORM

Name:_____ Date of Birth:_____ Date form last updated_____

Your complete medication history is important to your physicians. Please fill out this form and bring it with you. If for some reason you are unable to fill out this form, please bring in a bag of all of the medications (in their original containers) that you are currently taking.

Allergies: Are you allergic to medications, iodine, food, tape, or latex?
List each substance you are allergic to and the reaction you experienced.

Allergy	Reaction	Allergy	Reaction

Vaccines: Check one box for each vaccine.

Tetanus	Pneumonia	Influenza (Flu)	Pediatric (or child)
☐ Within past 10 years ☐ Unknown	☐ Within past 5 years ☐ Unknown	☐ Within the past year ☐ Unknown	☐ Up-to-Date ☐ Unknown

Medications: Please list all prescription and non-prescription medications, herbals, eye drops, nutritional supplements, inhalers, etc. that you use.

Name of Medicine	Dose (mg. units, puffs).	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?

Personal Medication Form continued

Name of Medicine	Dose (mg. units, puffs).	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?

Past Surgeries (Operations)	Year

Contact Information:

Doctor's name: _____ **Dr. Phone:** (____) _____

Pharmacy name: _____ **Pharmacy phone:** (____) _____

Emergency contact: Name: _____ **Phone:** (____) _____

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