

# My Personal Medication Record

## ➤ My Personal Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## ➤ Emergency Contact

Name: \_\_\_\_\_

Relationship & Phone Number: \_\_\_\_\_

## ➤ Primary Care Physician

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## ➤ Pharmacy/Drugstore

\_\_\_\_\_

Pharmacist: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## ➤ Other Physicians

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Phone number: \_\_\_\_\_

## ➤ My Allergies

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\_\_\_\_\_

\_\_\_\_\_

## How to use this Guide:

- Use this record to keep track of your medications, including prescription drugs, over-the counter (OTC) drugs, herbal supplements, and vitamins.
- Share the information with your doctors and pharmacists at all visits.
- Keep it always with you.
- Use a pencil.

## You should review this record when:

- Starting or stopping a new medicine.
- Changing a dose.
- Visiting your doctor or pharmacist.

Last updated: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## ➤ My Medical Conditions

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What I'm Taking	Reason for Use	Form <i>(pill, patch, liquid, injection, etc.)</i>	Dosage	How Much & When	Use <i>(regularly or occasionally)</i>	Start/Stop Dates <i>(1/05/05 - 3/05/05) (1/01/94 - ongoing)</i>	Notes or Special Directions
①							
②							
③							
④							
⑤							
⑥							
⑦							
⑧							
⑨							
⑩							

**\*Be sure to include ALL prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.**