MY MEDICATION RECORD

Complete this form, save to your computer and print it. Keep it with you at all times and update when necessary. List prescriptions, over-the-counter drugs, vitamins and herbal medicines. Bring this form to doctor's appointment, emergency department or hospital visits. If you have any complications with medications, immediately contact your doctor.

Patient name:_____ Birth date:_____/_____/_____

Pharmacy name:_____ Phone: (_____) _____

Primary care doctor name: _____ Phone: (_____) _____

Emergency contact: _____ Phone: (_____) _____

Allergies:_____

Start Date	Medication (name/dose)	Medication treats (condition)	Medication Frequency *Morning*	*Noon*	*Evening*	*Bedtime*	Notes

Milford Regional Medical Center

IMMUNIZATIONS

Date of last flu vaccine:_____

Date of last pneumonia vaccine:_____

Date of last tetanus:_____