

After any hospitalization, check with your doctor or nurse to review and update this medication list.

Patient Medication Card



Information about you

Your name: _____

Address: _____

Birth Date: _____ Blood Type: _____ Weight: _____ Height: _____

name

phone

Pharmacy: _____

Primary care doctor: _____

Other physicians: _____

(specialists) _____

Emergency Contact: _____

Medical Conditions

asthma heart disease diabetes high blood pressure

cancer kidney disease other _____

Over-the-Counter Medications

(Remember to write on other side.)

- Allergy relief, antihistamines
- Antacids
- Aspirin/other pain, headache, or fever
- Arthritis medications
- Cold/cough medications
- Diet pills
- Herbals, dietary supplements
- Laxatives Others (list below):
- Sleeping pills
- Vitamins, minerals

Allergies or Substitutions

Medication, Food, Environmental	Allergy, Side Effects, Reaction or Intolerance Experiences (symptoms, severity, dates)

Comments About My Health

Surgeries:

Vaccinations

Influenza: _____

Pneumococcal: _____

MMR: _____

Tetanus/Diphtheria: _____

