PATIENT MEDICATION RECORD

Complete the information below regarding all medications including; prescription, non-prescription, herbals or supplements you are currently taking. Keep this list updated and with you at all times, especially when you visit your physician or are admitted to the hospital.

(Please Print)

PATIENT INFORMATION				
Last Name:	First:	Middle:	Birth date: / /	
Street address:			Home phone: ( )	
P.O. box:	City:		State:	ZIP Code:
Primary Care Doctor:			Primary Care Doctor Phone:	
Pharmacy Name:			Pharmacy Phone:	

IN CASE OF EMERGENCY	
Contact Name:	Contact Phone:
Next of Kin Name:	Next of Kin Phone:

CURRENT MEDICATION – PRESCRIPTION & OVER-THE-COUNTER			
Example: Reglan	*10mg*	*4 Times Daily*	*Stomach Problems*
Name of Current Medication(s):	How Much?	How Often?	For Treatment of…
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

ALLERGIES – FOOD, MEDICATION & ENVIORNMENTAL	
Allergic To:	Describe Reaction:

IMMUNIZATION HISTORY		
Record the date/year of last dose taken, if known		
Tetanus:	Flu Vaccine(s):	
Pneumonia Vaccine:	Hepatitis Vaccine:	Other:

For additional copies of the Patient Medication Record, visit TriStarHealth.com