

My Medication Card

Name: _____

Address: _____

Phone: _____

Phone: _____

(Please fold on line)

Allergies

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

Diet:

Physician, Pharmacy, Emergency Contacts

Physician: _____

Phone: _____

Physician: _____

Phone: _____

Pharmacy: _____

Phone: _____

Pharmacy: _____

Phone: _____

Emergency Contact: _____

Phone: _____

(Please fold on line)

(Please fold on line)

Medical History

Please check those that apply:

- Asthma Heart Disease
 Diabetes Kidney Disease
 Cancer High Blood Pressure

Other: _____

Over-the-Counter Medications

Check those you use regularly:

- Allergy relief, Antihistamines
 Antacids
 Aspirin/Tylenol/Ibuprofen
 Cold/Cough Medicines
 Diet Pills
 Herbals, dietary supplements
 Laxatives
 Sleeping Pills
 Vitamins or Minerals
 Other: _____



(Record the date and year
of last dose taken if known)

Other: _____

Hepatitis: _____

Pneumonia Vaccine: _____

Other: _____

Flu Vaccine (s): _____

Tetanus: _____

Immunization Record

My Medication/ Information Card

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