Personal Medication Record

Print the following pages, complete the information and bring with you to your next hospital visit.
We are encouraging our patients to actively participate in their healthcare.

Name: _____ **Birthdate**: _____

Date: _____ **Height**: _____ **Weight**: _____

List all the medications prescribed by a physician that you are currently taking:

Medication	Dose	How often do you take it?	How long have you been taking it?	What is it for?

Name: _____ **Birthdate**: _____

Date: _____ **Height**: _____ **Weight**: _____

List all the non-prescription medicines that you take on a regular basis:

Medication	Dose	How often do you take it?	How long have you been taking it?	What is it for?

Name: _____ **Birthdate**: _____

Date: _____ **Height**: _____ **Weight**: _____

List all the vitamins, herbals, and nutritional supplements that you take on a regular basis:

Medication	Dose	How often do you take it?	How long have you been taking it?	What is it for?

Name: _____ **Birthdate**: _____

Date: _____ **Height**: _____ **Weight**: _____

My Allergies:

Are you allergic to any drugs? **Yes** ☐ **No** ☐
If yes, what type of reaction did you have?

Are you allergic to any foods? **Yes** ☐ **No** ☐
If yes, what type of reaction did you have?

Are you allergic to rubber/latex? **Yes** ☐ **No** ☐
If yes, what type of reaction did you have?

More Information:

Have you ever received anesthesia? **Yes** ☐ **No** ☐
Did you have an unexpected reaction to anesthesia?
If yes, describe:

Have you ever received blood? **Yes** ☐ **No** ☐
Did you have an unexpected reaction to blood?
If yes, describe: