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PERSONAL MEDICATION RECORD

Name: ______________________ Date of Birth: / /

Allergies: ______________________

Physician: ______________________ Physician Phone #: ______________________

Pharmacy ______________________ Pharmacy Phone #: ______________________

Name of Medication (Prescriptions, over-the-counter, eye drops, supplements, patches, herbals inhalers, implanted pumps)	**Dose of Medication** (Example: one 20 mg tablet)	**Reason for Taking Medication**

*Please update this card whenever changes to your medication are made. Always document to keep a record for yourself and your healthcare provider.

Name of Person Updating this Card	**Date**	**Relationship to Patient**

KEEP A COMPLETED & UP-TO-DATE CARD WITH YOU AT ALL TIMES