Medication Review

fold along the lines and keep with you

Name:
Date of Birth:
Emergency Contact/Phone #s:
Doctor(s):
Pharmacies/Other Sources:

Immunizations:

Flu Vaccine(s):
Pneumonia Vaccine:
Tetanus:
Hepatitis Vaccine:
Other: (type) date:

Allergic To:

List the medicines you are now taking. Include prescriptions, over-the-counter medications, and herbal remedies.

Medication Name	Dosage	How is it Taken?	Reason for Taking and/or How does it make you feel?