Personal Medication Form

Name: _____ Date of birth: _____ Date form last updated: _____

Your complete medication history is important to your healthcare team. Please fill out this form and bring it with you anytime you go to the doctor's office or to the hospital. If you are scheduled for a Pre-Admission Surgical appointment, make a trip to the Emergency Room, or are coming directly to the hospital – Remember to bring this completed form!!
If for some reason you are unable to fill out this form, please bring in a bag of all of the medications (in their original containers) that you are currently taking.

Allergies: **Are you allergic to medications, iodine, food, tape, or latex?**
List each substance you are allergic to and the reaction you experienced.

Allergy	Reaction	Allergy	Reaction

Vaccines: **Check one box for each vaccine.**

Tetanus	Pneumonia	Influenza (Flu)	Pediatric (for child)
☐ Within past 10 years ☐ Unknown	☐ Within past 5 years ☐ Unknown	☐ Within the past year ☐ Unknown	☐ Up-to-date ☐ Unknown

Medications: **Please list all prescription and non-prescription medications, herbals, eye drops, nutritional supplements, inhalers, etc that you use.**

Name of medicine	Dose (mg, units, puffs)	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?

List additional medications AND any medications that you have recently stopped – on the back

Adopted from Legacy Health System

Personal Medication Form continued

Name of medicine	Dose (mg, units, puffs)	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?
Medications completed within the last week: (List any medications being held prior to a scheduled surgery, and any that you recently completed).				

Contact Information:

Doctor's name: _____ **Dr. Phone: (____)** _____

Pharmacy name: _____ **Pharmacy phone: (____)** _____

Emergency contact: Name: _____ **Phone: (____)** _____