THE MED FORM

Name:______________________________ Date Completed:____________
Preferred Pharmacy/Phone:______________________________________
Address:____
Phone Number:__________________________ Birth Date:____________
Emergency Contact/Phone:_______________________________________

Allergies and Drugs to Avoid/Adverse Reactions:

____
____
____

Current Medications:

List all medications you are taking, include over-the-counter (e.g., aspirin, antacids, vitamins and herbals).

Medication:______________________________ Dosage:______________
Reason for Taking:_______________ Directions:__________________
Doctor:__________________________ Date Started:________________

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Reason for Taking:_______________ Directions:__________________
Doctor:__________________________ Date Started:________________

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Reason for Taking:_______________ Directions:__________________
Doctor:__________________________ Date Started:________________

Medication:______________________________ Dosage:______________
Reason for Taking:_______________ Directions:__________________
Doctor:__________________________ Date Started:________________

Always keep this form with you.

(over)

Current Medications: *(continued)*

Medication:________________________________ Dosage:________________
Reason for Taking:________________ Directions:____________________________
Doctor:____________________________ Date Started:______________________

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Reason for Taking:________________ Directions:____________________________
Doctor:____________________________ Date Started:______________________

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Medication:________________________________ Dosage:________________
Reason for Taking:________________ Directions:____________________________
Doctor:____________________________ Date Started:______________________

Immunization Record:

(Include dates administered)

❏ Tetanus__________ ❏ Pneumonia Vaccine__________ ❏ Flu Vaccine__________
❏ Hepatitis B Vaccine_________ ❏ Other________________________________

Always keep this form with you.