



# My Personal Medication Record

- For your safety and good health, use this handy form to list all of your medications, including prescription drugs, over-the-counter (OTC) drugs, herbal supplements, and vitamins.
- Ask your Walgreens pharmacist for a print out of your prescription drug history.
- Share this list with your health care providers at all visits so there is common agreement on what you are taking and to avoid drug-drug interactions.
- Make copies. Give them to loved ones and keep one with you at all times.
- Update your record when starting or stopping a new medication or changing a dose.

## ► My Medical Conditions

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

## ► My Personal Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## ► Emergency Contact

Name: \_\_\_\_\_

Relationship & Phone Number: \_\_\_\_\_

## ► Primary Care Physician

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## ► Pharmacy/Drugstore

\_\_\_\_\_

Pharmacist: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## ► Other Physicians

Name: \_\_\_\_\_

*Specialty:* \_\_\_\_\_

*Phone Number:* \_\_\_\_\_

Name: \_\_\_\_\_

*Specialty:* \_\_\_\_\_

*Phone Number:* \_\_\_\_\_

Name: \_\_\_\_\_

*Specialty:* \_\_\_\_\_

*Phone Number:* \_\_\_\_\_

## ► My Allergies

---

---

---

---

Medicine Name (B-Brand G-Generic)	Reason for Use	Form (pill, patch, liquid, injection, etc.)	Dosage	How Much & When	Use (regularly or occasionally)	Start/Stop Dates (1/05/05 – 3/05/05) (1/01/94 – ongoing)	Notes or Special Directions
①							
②							
③							
④							
⑤							
⑥							
⑦							
⑧							
⑨							
⑩							

\*Be sure to include ALL prescription drugs, over-the-counter drugs, vitamins, and dietary/herbal supplements.