MY MEDICATION INFORMATION

Patient:

- 1. ALWAYS KEEP THIS FORM WITH YOU. You may want to fold it and keep it in your wallet along with your driver's license. Then it will be available in case of an emergency.
- 2. Write down all of the medicines you are taking and list all of your allergies.
- 3. Take this form to ALL doctor visits, when you go for tests and ALL hospital visits.
- 4. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. If you stop taking a certain medicine, draw a line through it and write the date it was stopped. If help is needed, ask your Doctor, Nurse, Pharmacist, or family member to help you to **keep it up-to-date**.
- 5. In the PURPOSE column, write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).
- 6. When you are discharged from the hospital, someone will talk with you about WHICH MEDICINES TO TAKE AND WHICH MEDICINES TO STOP TAKING. Since many changes are often made after a hospital stay, a new form should be filled out. When you return to your doctor, take your new form with you. This will keep everyone up-to-date on your medicines.

HOW DOES THIS FORM HELP YOU?

- 1. This form helps you and your family members **remember** all of the **medicines you are taking** and provides your doctors with a **current list of ALL of your medicines**. Doctors need to know the herbals, vitamins, and over-the-counter medicines you take!
- 2. Helps you remember what medicines you are taking, how you are taking them and why.

To obtain more copies, please contact the Dallas-Fort Worth Hospital Council at 972-719-4900. A wallet-sized card can also be downloaded at www.dfwhc.org.



MY MEDICATION INFORMATION

| Fold this form and keep it in your wallet | Date form started: |
|---|--------------------|
| Name: | Address: |
| Phone Number: | |
| Birth Date: | |
| Emergency Contact/Phone Numbers: | |

Doctor's Name/Phone:

Pharmacist/Phone:

| IMMUNIZATION RECORD (Record the date/year of last dose taken, if known) | | | | | |
|---|-------------------|----------------------|-----------|--|--|
| TETANUS | FLU VACCINE(S) | | | | |
| PNEUMONIA VACCINE | HEPATITIS VACCINE | | OTHER | | |
| Allergic to/Describe reaction: | | Allergic to/Describe | reaction: | | |
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LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

| DATE STARTED | NAME OF MEDICATION | DOSE mg, units, puffs, drops | WHEN DO YOU TAKE IT? How many times per day? Morning and night? After meals? | PURPOSE Why do you take it? |
|------------------------|--------------------|------------------------------------|--|---------------------------------------|
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