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: _____

Medication:_____ Dosage:_____

Reason for Taking:_____ Directions:_____

Doctor:_____ Date Started: _____

Medication:_____ Dosage:_____

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: _____

Medication:_____ Dosage:_____

Reason for Taking:_____ Directions:_____

Doctor:_____ Date Started: _____

Medication:_____ Dosage:_____

Reason for Taking:_____ Directions:_____

Doctor:_____ Date Started: _____

Medication:_____ Dosage:_____

Reason for Taking:_____ Directions:_____

Doctor:_____ Date Started: _____

Medication:_____ Dosage:_____

Reason for Taking:_____ Directions:_____

Doctor:_____ Date Started: _____

Immunization Record:

(Include dates administered)

Tetanus_____ Pneumonia_____ Flu_____

Hepatitis B Vaccine_____ Other_____