MEDICATION FORM

Bring this form when you see a physician including your primary doctor or any type of emergency care.

Name:

Phone:

Address:

Emergency Contact Name:

Emergency Contact Phone:

Physician:

Phone:

Physician:

Phone:

Pharmacy:

Phone:

Allergies and Reactions:

What medications should I include on this form?

- Prescription drugs
- Over-the-counter medicines
- Dietary/herbal remedies
- Respiratory therapy medication
- Vitamins or minerals

Questions to Ask

- What is the name of the medication and what is it for?
- How and when should I take it and how much should I take?
- What should I do if I miss a dose?
- When and how should I stop taking it?
- Will it interact with other prescription or over-the-counter medications, herbal, or vitamins that I take?
- Should it be taken with food? What food or drinks should I avoid while taking this medication?
- What are the side effects and what should I do if I experience them?

Remember to review and update your medication card!

Last Date of Adult Immunizations

Pneumonia:

Tetanus:

Hepatitis:

Flu:

Start Date of Medication *Example: 7/05/10*	Name of Medication and Strength *Example: citalopram, 20mg*	Dose How many pills, units, drops, puffs? *Example: 1 pill*	When do you take it? How many times a day? Morning and/or night? After or with meals? *Example: 1x day, morning*	Purpose of Medication *Example: Depression*

MENTAL HEALTH ASSOCIATION of Minnesota MHAM

www.mentalhealthmn.org

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