My Medication Record

Name: _____ Date Completed: _____

Address: _____

Phone Number: _____ Birth Date: _____

Emergency Contact/Phone: _____

Preferred Pharmacy/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: _____
Directions: _____
Reason for Taking: _____
Doctor: _____
Date Started: _____

Medication: _____
Dosage: _____
Directions: _____
Reason for Taking: _____
Doctor: _____
Date Started: _____

Medication: _____
Dosage: _____
Directions: _____
Reason for Taking: _____
Doctor: _____
Date Started: _____

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Medication: _____
Dosage: _____
Directions: _____
Reason for Taking: _____
Doctor: _____
Date Started: _____

Medication: _____
Dosage: _____
Directions: _____
Reason for Taking: _____
Doctor: _____
Date Started: _____

Always keep this form with you. More space next page.

Medication: ____________________

Dosage: ____________________

Directions: ____________________

Reason for Taking: ____________________

Doctor: ____________________

Date Started: ____________________

Medication: ____________________

Dosage: ____________________

Directions: ____________________

Reason for Taking: ____________________

Doctor: ____________________

Date Started: ____________________

Medication: ____________________

Dosage: ____________________

Directions: ____________________

Reason for Taking: ____________________

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Date Started: ____________________

Medication: ____________________

Dosage: ____________________

Directions: ____________________

Reason for Taking: ____________________

Doctor: ____________________

Date Started: ____________________

Medication: ____________________

Dosage: ____________________

Directions: ____________________

Reason for Taking: ____________________

Doctor: ____________________

Date Started: ____________________

Immunization Record:

(Include dates administered)

- ☐ Tetanus ________ / ________ / ________
- ☐ Pneumonia Vaccine ________ / ________ / ________
- ☐ Flu Vaccine ________ / ________ / ________
- ☐ Hepatitis B Vaccine ________ / ________ / ________
- ☐ Other____________________

Always keep this form with you. More space next page.

Dignity Health.
Yavapai Regional Medical Center

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