Updated [   ]

Name of Medication	Dose	Time(s)

List all prescription and over-the-counter (non-prescription) medications (Example: Aspirin, St. John's Wort, Vitamins).
Please include prescription meds taken as needed (Example: Nitroglycerin, pain medications, inhalers, eye drops.)

Allergies: (include what happens)

_____

_____

ST. JOSEPH'S
Hospital 🜊 Health Center

Personal Medication Record

Name

Phone _____

Emergency Contact:

Name _____

Phone _____

Doctor _____

Phone _____

Pharmacy _____

Phone _____

Health Information: *Date*

Flu Shot _____

Pneumonia Vaccine _____

Hepatitis _____

Tetanus _____

Other _____

Keep this list with you
- ✓ Bring this list to your doctor visits, the hospital and all medical tests.
- ✓ Update this form when