



## PATIENT MEDICATION RECORD

Complete the information below regarding all medications including; prescription, non-prescription, herbals or supplements you are currently taking. Keep this list updated and with you at all times, especially when you visit your physician or are admitted to the hospital.  
(Please Print)

PATIENT INFORMATION			
Last Name:	First:	Middle:	Birth date:    /    /
Street address:		Home phone: (    )	
P.O. box:	City:	State:	ZIP Code:
Primary Care Doctor:		Primary Care Doctor Phone:	
Pharmacy Name:		Pharmacy Phone:	
IN CASE OF EMERGENCY			
Contact Name:		Contact Phone:	
Next of Kin Name:		Next of Kin Phone:	
CURRENT MEDICATION – PRESCRIPTION & OVER-THE-COUNTER			
Example: Reglan	10mg	4 Times Daily	Stomach Problems
Name of Current Medication(s):	How Much?	How Often?	For Treatment of...
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
ALLERGIES – FOOD, MEDICATION & ENVIRONMENTAL			
Allergic To:		Describe Reaction:	
IMMUNIZATION HISTORY			
Record the date/year of last dose taken, if known			
Tetanus:		Flu Vaccine(s):	
Pneumonia Vaccine:		Hepatitis Vaccine:	Other:

**For additional copies of the Patient Medication Record, visit [TriStarHealth.com](http://TriStarHealth.com)**