UNIVERSAL MEDICATION FORM

Keep this form with you at all times and give a copy to someone close to you.

Date form started:

DETAILS			
NAME:			
BIRTH DATE:			
ADDRESS:		**PHONE NUMBERS**	**EMERGENCY CONTACT**
		Home:	Name:
		Work:	Relation:
		Mobile:	Phone:
SEX: (Check mark one): ☐ Male ☐ Female:			
Height:		Weight:	

IMMUNIZATION Record (Record the date/year of last dose taken, if known)	
TETANUS:	
FLU VACCINE(S)	
PNEUMONIA VACCINE	
HEPATITIS VACCINE	
OTHER:	

ALLERGIES (please describe reaction)		

DOCTOR / DENTIST / OTHER PRESCRIBER'S NAME	**PHONE NUMBER**	**TYPE OF PRACTITIONER / REASON FOR SEEING**

PHARMACY NAME	**PHONE NUMBER**	**STREET/CITY/STATE**

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ADDITIONAL INFORMATION / COMMENTS

COMPLETE LIST OF CURRENT MEDICATIONS:

List all the medication you are taking (including pills, patches, ointments, injections, etc.) regularly and on an as needed basis. Include any over the counter medications, supplements and herbal products.

MEDICATION (Brand & Generic Name)	**DOSE**	**DIRECTIONS:** **Use patient friendly directions. (Do not use medical abbreviations)**	**DATE STARTED**	**DATE STOPPED**	**NOTES:** **REASON FOR TAKING / DOCTOR NAME**

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PATIENT:

1. **ALWAYS KEEP THIS FORM WITH YOU.** You may want to fold it and keep it in your wallet along with your driver's license. Then it will be available in case of an emergency.
2. Write down all of the medicines you are taking and list all of your allergies. List any reaction you have experienced from medicines that required you to stop taking that medicine such as allergies or bad side effects. Also include any allergy to dye, food, or insects, etc. Also write what happens to you if you are exposed to these things.
3. Take this form to **ALL DOCTOR VISITS**, when you go for tests and **ALL** hospital visits.
4. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. If you stop taking a certain medicine, draw a line through it and write the date it was stopped. If help is needed, ask your Doctor, Nurse, Pharmacist, or family member to help you to **keep it uptodate.**
5. Pharmacy: List their names, phone number, and location in case there are questions.
6. In the NOTES column, write down the name of the doctor who told you to take the medicine(s). You may also write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).
7. When you are discharged from the hospital, someone will talk with you about **WHICH MEDICINES TO TAKE AND WHICH MEDICINES TO STOP TAKING**. Since many changes are often made after a hospital stay, a new form should be filled out. When you return to your doctor, take your new form with you. This will keep everyone up to date on your medicines.

HOW DOES THIS FORM HELP YOU?

1. This form helps you and your family members **remember** all of the **medicines you are taking**.
2. Provides your doctor(s) and others with a **current list of ALL of your medicines**. Doctors need to know the herbals, vitamins, and overthecounter medicines you take!
3. Concerns may be found and problems prevented by knowing what medicines you are taking.

WOORi Pharmacy

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