

Medication Matters!

Name _____

Pharmacy Information

Primary Pharmacy _____

Pharmacy Phone _____

My Health Conditions Include:

- | | | | | | |
|------------------------------------|--|--|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Dentures/partial | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Lens Implant | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |

Advance Directives I Have Completed: Living Will Durable Power of Attorney for Health Care Neither

Past Surgeries	Year

Allergies (Medications, Foods, Latex, other)	Reaction

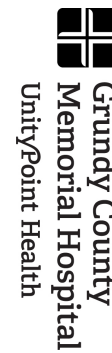
Immunization Dates: Tetanus _____ Flu _____ Pneumonia _____

Medical Insurance Information

Primary Medical Insurance Name _____

Number _____

Secondary name/number _____



Personal Health Record

Name _____

Date of Birth _____

Doctor _____

Doctor's Phone _____

Emergency Contact

Name _____

Phone _____

Medication Matters!

Update this card and keep it with you at all times. Remember to ask your doctor or pharmacist:

- What is the name of the medication and what is it supposed to do?
- How and when do I take it — and for how long?
- What foods, drinks other medicines or activities should I avoid while taking this medication?
- Are there any side effects? What should I do if they occur?
- Is there written information available about the drug?

Personal Medication Record

For _____ Phone _____

Height _____ Weight _____

- List all medications you are taking, **including** over-the-counter drugs, supplements, herbal products, eye drops, inhalers, oxygen, etc.
- Do not list medications you will be on for less than two weeks (for example antibiotics).
- Use a pencil so changes can be made.

Date <i>(added/changed)</i>	Medication Name	Strength/Dosage	How Often	Why do you take it?	Prescribing physician

Tips for your medication safety:

- Use only one pharmacy when possible.
- Always present this card at your doctor’s office to be reviewed and updated.
- Always have your pharmacist review this card when a new prescription is added.
- Always carry this card with you.
- Use pencil for easy changes.
- Always keep this card current!

To learn more or download additional copies go to:
unitypoint.org/grundycounty/medication-matters.

