

Universal Medication Form

Name: _____ Date form started: _____

Birth Date: _____ Emergency Contacts (name and number)

Address: _____ 1 _____ () _____ - _____

Phone Number: _____ 2 _____ () _____ - _____

IMMUNIZATION RECORD (Record the date/year of the last dose taken, if known)

Tetanus _____ Flu Vaccine(s) _____ Other _____

Pneumonia Vaccine _____ Hepatitis Vaccine _____

Allergic To	Describe Reaction	Allergic To	Describe Reaction

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerin).

DATE	Name of Medication and Dose	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	NOTES: Reason for taking and Doctors Name