



THE MED FORM

Name: _____ Date Completed: _____
Preferred Pharmacy/Phone: _____
Address: _____
Phone Number: _____ Birth Date: _____
Emergency Contact/Phone: _____

Allergies and Drugs to Avoid/Adverse Reactions:

Current Medications:

List all medications you are taking, include over-the-counter (e.g., aspirin, antacids, vitamins and herbals).

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Doctor: _____ Date Started: _____

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Reason for Taking: _____ Directions: _____
Doctor: _____ Date Started: _____

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Reason for Taking: _____ Directions: _____
Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Doctor: _____ Date Started: _____

Current Medications: *(continued)*

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

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Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Immunization Record:

(Include dates administered)

Tetanus _____ Pneumonia Vaccine _____ Flu Vaccine _____

Hepatitis B Vaccine _____ Other _____



Always keep this form with you.