My Personal MEDICATION RECORD

_____
Name

_____
Phone

Provided by your family physician and

MILTON HOSPITAL
AN AFFILIATE OF
Beth Israel Deaconess
Medical Center

199 Reedsdale Road, Milton, MA 02186
www.miltonhospital.org

Keep a current list of every medicine you are taking.

- **Prescriptions**
- **Over-the-counter medications**
- **Dietary supplements such as vitamins and herbs**

Make sure ALL your doctors know what you are taking. Give them a copy of your list. If necessary, bring your medicines with you so your doctor(s) can see them.

My Primary Physician

Name: _____
City: _____
Phone: _____

My Pharmacy

Name: _____
City: _____
Phone: _____

Emergency Contact

Name: _____
Phone: _____

For your purse or wallet. Keep with you at all times.

Allergies & Reactions:

_____
_____
_____
_____
_____
_____

Date of Last Immunizations:

Tetanus _____
Pneumococcal _____
Influenza _____
Other _____

Form No: B4-14 (Rev. 03/09)

Medication	Dosage	How Often	Purpose	Doctor
XXX (Example)	40 mg	1 Daily	Water Pill	Jones