ST. JOSEPH'S Hospital Health Center

12648

Personal Medication History

Date Last Updated:

Name:	**Birth Date:**
Pharmacy – Name and phone number	**Doctor(s):**

Allergic to: (also describe your reaction)

******List all prescription and over-the-counter (non-prescription) medications (Example: St. John's Wort, Vitamins). Please include prescription medications taken as needed (Example: Nitroglycerin, pain medication, inhalers, aspirin, eye drops).

Name of Medication	Dose	Time(s) taken	Reason for Medication	Date stopped

Immunization Record (include date given)	
Tetanus:	**Hepatitis:**
Pneumonia:	**Flu:**

Keep this list with you.
Bring this list to your doctor visits, the hospital and all medical tests.
✓ Update this form when medications change.
✓ Copies of this form on www.sjhsyr.org