UNIVERSAL MEDICATION FORM

Name:_____ Date form started:_____

BirthDate:_____ 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 (example: 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