

My Medication Record

Name: _____

Date this form was last updated: _____

Last updated by: _____

Emergency contact name: _____

Emergency contact phone number: _____

Pharmacy name: _____ Pharmacy phone number: _____

This is your personal medication record. Please complete it as much as possible. You can share it with any healthcare provider or caregiver. Filling it out helps set you up for success. You can find information about your medications on the vial, from your family doctor and from your pharmacist. Sharing this record with the healthcare team ensures that you and they can make good decisions about your medications and your care. Please bring it to all meetings about your medications.

List any allergies. Be sure to describe what the reaction was for each allergy and when it happened.

List any bothersome side effects to any medications. Be sure to describe what the side effect was for each medication and when it happened.

Current medications

Include all prescription and over-the-counter drugs, vitamins and supplements. Don't forget to list any eye/ear drops, patches, creams, inhalers, nasal sprays or injections.

Medication name and how I take it: (dose, when and how often, how I take it (e.g., by mouth, in the eyes or ears, on the skin etc.)	Reason(s) for use	I started this medication ... (date, months or years ago)	I was told to take this medication for...' (months, years, for the rest of my life, don't know)	Prescribed by	Additional information (e.g., changes in doses, side effects I watch for, did it help my symptoms? Do I do any monitoring at home and what are the results?)

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Medications that have been stopped

Medication name and how I took it (dose, when and how often, including how I take it (e.g. by mouth, in the eyes or ears, on the skin etc.))	Reason(s) for use	When was I taking this?	Reason for stopping

Medications were supplied from the pharmacy in (check all that apply): vials blisterpack other

Please list any special instructions/concerns around taking your medications (eg. trouble swallowing pills, medications being crushed)

Vaccination history:

Vaccine	Date of last dose
Influenza	
Shingles ((Shingrix, Zostavax)	
Pneumococcal (Pevnar 13, Pneumovax 23)	
Tetanus and Diphtheria	
COVID-19	