My Medication History and Experience

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Name: _____

Date Updated: _____

Updated by: _____

Emergency contact name: _____

Emergency contact phone number: _____

Pharmacy name: _____ **Pharmacy phone number:** _____

This is a tool to record a medication history for you or the person you care for. **Complete it as much as possible.** You can find information about the medications on the vial and by asking the doctor, nurse practitioner, nurse or pharmacist. Bring this record to all medical appointments and meetings about medications, so you and the healthcare team can make the right medication decisions. Update this record each time a medication is added or stopped, or a dose changes. Review medications regularly with the healthcare team to see if all of them are still needed.

List any medication allergies. Describe what the reaction was for each medication and the date it happened.

List any intolerances or severe drug reactions. Describe what the reaction was for each medication and the date it happened.

Medications in pill form are kept organized with (example – blister packs):

_____

List any special instructions/concerns around taking medications (e.g., trouble swallowing pills, medications being crushed or split, anyone that helps organize/give medications, troubles with remembering). *If medications are given differently, like in split pieces, crushed or through a feeding tube, always check with a pharmacist to make sure it is safe to do so.

Current Medications

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Include all prescriptions, over-the-counter drugs, vitamins, supplements, herbals or any other products taken. Don't forget to list any eye/ear drops, patches, creams, inhalers, liquids, powders, nasal sprays or injections.

Medication name and how taken (dose, when and how often, how taken - by mouth, in the eyes or ears, on the skin)	**Reason(s) for taking**	**When started** (date, months or years ago)	**How long was it needed for** (months, years, for life, don't know)	**Prescribed by**	**Additional information** (e.g., changes in doses, side effects to watch for, did it help? Monitoring done at home and what are the results?)

Medications that have been stopped

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Medication name and how taken (dose, when and how often, how taken - by mouth, in the eyes or ears, on the skin)	Reason(s) for taking	When started and stopped	Reason for stopping

Vaccination History

Vaccine	Date of last dose or doses
Influenza	
Shingles (Herpes Zoster)	
Pneumococcus	
Tetanus	
COVID-19	
Respiratory Syncytial Virus (RSV)	
Other: _____ _____ _____	

Lifestyle Choices

These details are important to share because they can affect how your medications work or affect your health. Write down details like the name or type of product, how much (in a day, in a week), when taken, when started, if you used it in the past and when/why it was stopped, and the reason(s) for taking.

Product	Yes or No?	Details
Smoking, Nicotine	Yes	
Alcohol	Yes	
Caffeinated drinks/ products	Yes	
Cannabis (e.g., CBD, THC, marijuana)	Yes	
Recreational Drugs	Yes	