Beaumont

PERSONAL MEDICATION RECORD

Name: ______________________________ **Date of Birth:** ______________________

Allergies: ____

Physician: ______________________________ Physician Phone #: ______________________

Pharmacy ______________________________ Pharmacy Phone #: ______________________

Name of Medication (Prescriptions, over-the-counter, eye drops, supplements, patches, herbals, inhalers, implanted pumps)	**Dose of Medication** (Example: one 20 mg tablet)	**How Often Do You Take This Medication?** (Examples: three times a day, at bedtime)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

KEEP A COMPLETED & UP-TO-DATE CARD WITH YOU AT ALL TIMES

Courtesy of Beaumont Hospitals

4595 011410 OS4

(Additional room on back of form)

Name of Medication (Prescriptions, over-the-counter, eye drops, supplements, patches, herbals, inhalers, implanted pumps)	Dose of Medication (Example: one 20 mg tablet)	How Often Do You Take This Medication? (Examples: three times a day, at bedtime)
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		

*Please update this card whenever changes to your medications are made. Always document to keep a record for yourself and your healthcare provider.

Name of person updating this card	Date	Relationship to Patient

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Courtesy of Beaumont