Medication Journal

On this journal:

- **List all medications you are taking (prescription, nonprescription, vitamins, herbal products, dietary supplements, sample medications, eye drops, inhalation therapy, injections and oxygen).**
- **Bring this to every doctor and pharmacy visit.**
- **Cross off medicine you no longer take.**
- **Keep this journal with you at all times.**

My Name/Phone: ____

Emergency Contact Name/Phone: ______________________________

Pharmacy Name/Phone: ______________________________________

Primary Care Physician Name/Phone: __________________________

Pneumovax Date: ____

Tetanus Date: ____

Flu Vaccine Date: ____

Over the Counter Medications

☐ Aspirin ____________________	☐ Laxatives ____________________
☐ Acetaminophen ______________	☐ Antacids _____________________
☐ Ibuprofen __________________	☐ Diet Pills ____________________
☐ Cold Medicine ______________	☐ Other ________________________
☐ Cough Medicine _____________	☐ Other ________________________
☐ Allergy Relief ______________	☐ Other ________________________

Notes: Other physicians, surgeries, implants (pacemaker, stents, Mediport), etc.

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MEDICATION / DIETARY SUPPLEMENTS / VITAMINS / HERBALS	STRENGTH / QUANTITY / HOW OFTEN	PURPOSE	DOCTOR / DATE PRESCRIBED

MY ALLERGIES / REACTIONS