My Name/Phone _____

Emergency Contact Name/Phone _____

Pharmacy Name/Phone _____

Primary Care Physician Name/Phone _____

Pneumovax Date _____

Tetanus Date _____

Flu Vaccine Date _____

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

_____

_____

_____

_____

_____

_____

My Allergies/Reactions

_____

_____

_____

_____

- List all medicines 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 card with you at all times.

McDonough District Hospital

Medication Wallet Card

Questions?

(309) 836-1584

MEDICATION	PURPOSE	DOSE/FREQUENCY	DOCTOR/ DATE PRESCRIBED

Over the Counter Medications (Check all you use.)

❑ Allergy Relief ❑ Antacids ❑ Aspirin ❑ Diet Pills ❑ Cold Medicine

❑ Cough Medicine ❑ Laxatives ❑ Acetaminophen ❑ Ibuprofen

❑ Other _____

Dietary Supplements/Vitamins/Herbals

Name	Dose	How Often		