

# Medication Matters!

Name \_\_\_\_\_

## Pharmacy Information

Primary Pharmacy \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_

## My Health Conditions Include:

- |                                    |  |  |  |  |  |
|------------------------------------|--|--|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke        | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Liver Problems    | <input type="checkbox"/> Dentures/partials | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Seizures      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Lens Implant      | <input type="checkbox"/> Hearing Aid   |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Contact Lenses    | <input type="checkbox"/> Pacemaker         | <input type="checkbox"/> Other _____   |

**Advance Directives I Have Completed:**  Living Will  Durable Power of Attorney for Health Care  Neither

Past Surgeries	Year

Allergies (Medications, Foods, Latex, other)	Reaction

**Immunization Dates:** Tetanus \_\_\_\_\_ Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_

## Medical Insurance Information

Primary Medical Insurance Name \_\_\_\_\_

Number \_\_\_\_\_

Secondary name/number \_\_\_\_\_



**Personal Health Record**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Doctor \_\_\_\_\_

Doctor's Phone \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_

Phone \_\_\_\_\_

*Take me to a  
UnityPoint Health® hospital*

## Doctor Information

Doctor \_\_\_\_\_

Doctor's Phone \_\_\_\_\_

**Medication Matters!**

Update this card and keep it with you at all times. Remember to ask your doctor or pharmacist:

- What is the name of the medication and what is it supposed to do?
- How and when do I take it — and for how long?
- What foods, drinks other medicines or activities should I avoid while taking this medication?
- Are there any side effects? What should I do if they occur?
- Is there written information available about the drug?

# Personal Medication Record

For \_\_\_\_\_ Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

- List all medications you are taking, **including** over-the-counter drugs, supplements, herbal products, eye drops, inhalers, oxygen, etc.
- Do not list medications you will be on for less than two weeks (for example antibiotics).
- Use a pencil so changes can be made.

Date <i>(added/changed)</i>	Medication Name	Strength/Dosage	How Often	Why do you take it?	Prescribing physician

## Tips for your medication safety:

- Use only one pharmacy when possible.
- Always present this card at your doctor's office to be reviewed and updated.
- Always have your pharmacist review this card when a new prescription is added.
- Always carry this card with you.
- Always keep this card current!

To learn more or download additional copies go to [unitypoint.org/ERMedicationMatters](http://unitypoint.org/ERMedicationMatters).

