UNIVERSAL MEDICATION FORM

Patient Name:_____ **Date of Birth:**_____
Height: _____**ft** _____**in** **Weight:**_____ **lbs**

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)	
PNEUMONIA VACCINE	FLU VACCINE(S)
Allergic To /Describe Reaction:	**Allergic To /Describe Reaction:**

LIST ALL MEDICATIONS YOU HAVETAKEN DURING THE LAST 30 DAYS: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

NAME OF MEDICATION	DOSE (mg, mcg, units, etc.)	DIRECTIONS: How often do you take this medication? (Daily, as needed, 3 times a day, etc.)	REASON FOR TAKING THIS MEDICATION

HOW DOES THIS FORM HELP YOU?

1. This form provides your doctor(s) and others with a **current list of ALL of your medications**. Doctors need to know the prescription, herbals, vitamins, and over-the-counter medicines you take to make medical decisions and provide optimal care.
2. This helps you, because physicians are able to identify potential medication interactions and develop an appropriate treatment plan during your stay.