UNIVERSAL MEDICATION FORM

Medicare Part D Plan/ID# **Date form started:**

Name:	**Address:**
Phone Number:	
Birth Date:	

Emergency Contact Phone Numbers:

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)

TETANUS	FLU VACCINES (S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To/Describe Reaction:	**Allergic To/Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko).
Include medications taken as needed (example: nitroglycerin).

Date	NAME OF MEDICATION/DOSE	DIRECTIONS Use patient friendly directions (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason For taking/ Doctor Name

KEEP THIS FORM IN THE POCKET PROVIDED, IN A CONVENIENT LOCATION (on your fridge)
See back of form for additional instructions