Willamette Valley Medical Center

Medication List

Information About You

Name: _____

Address: _____

Birth Date: _____ **Blood Type:** _____ **Weight:** _____ **Height:** _____

Pharmacy: _____ **Phone:** _____

Primary Physician: _____ **Phone:** _____

Other Physicians: _____ **Phone:** _____

or Specialists: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Medical Conditions

- ☐ **Asthma**
- ☐ **Heart Disease**
- ☐ **Diabetes**
- ☐ **High Blood Pressure**
- ☐ **Kidney Disease**
- ☐ **Cancer**
- ☐ **Other** _____

Medication and Food Allergy

Medication/Food/Environment that cause a reaction	Allergy/Side Effects, Reaction or Intolerance Experienced (symptoms, severity)

Vaccinations

(please note the date of the immunization)

Influenza: _____

Pneumococcal: _____

Tetanus/Diptheria: _____

Medications - Include over-the-counter products (OTC), Vitamins, Herbal

(please use a pencil to complete this form)

Name of Medication Brand and Generic Name (if available)	Dosage mg/units/puffs/drops	When is the medication taken? How many times a day? Morning and/or night? After meals?	Purpose

*** Always refer to physician and pharmacist input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. Whenever you see a doctor including your primary care physician and any specialist, review and update this medication list. After any hospitalization, check with your doctor to review this medication list.**