MEDICATION SUMMARY

My medical conditions include (circle or list):

Abnormal EKG
Angina
Arthritis
Depression
Diabetes
Epilepsy
Hearing impairment
Heart condition
Hemodialysis
High blood pressure
Pacemaker
Visual impairment

Other conditions (list):

I am allergic to (circle or list):

Insect bites
Aspirin
Antibiotics
Codeine
Other medications (list):

Food allergies (list):

NAME:

Doctors' names and phone numbers:

Medical Insurance Company and ID number:

Pharmacists' names and phone numbers:

Prescription Drug Plan and ID number:

Emergency contact numbers:

Name:
Relationship:
Phone numbers:

Name:
Relationship:
Phone numbers:

Name of prescription medicine	**What it is for**	**Doctor who prescribed**	**How and when to take**	**How much to take/dosage/strength**	**Color/ Shape**
Name of non-prescription medicine (include OTC, vitamins, minerals, herbs, and home remedies)	**What it is for**	**Doctor who prescribed**	**How and when to take**	**How much to take/dosage/strength**	**Color/ Shape**

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