Lucas County Health Center

An Affiliate of UnityPoint Health

Medication List

Your Information:

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: Home: _____ Cell: _____ Work: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Primary Pharmacy: _____ Phone #: _____

Primary Healthcare Provider: _____

Other Providers: _____ _____

Vaccination Dates

Influenza: _____ Pneumococcal: _____

MMR: _____ Tetanus/Diptheria: _____

Zostavax (Shingles): _____ Other: _____

Health History:

□ COPD □ Heart Disease □ Diabetes □ Cancer

□ High Blood Pressure □ Kidney Disease

□ Other _____

Surgeries: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Blood Type: _____

Allergies or Sensitivities:

Medication, Food, Environmental	Allergy, Side Effects, Reaction or Intolerance Experiences (symptoms, severity, dates)

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Medications: Include any over-the-counter medications, vitamins, herbal supplements, inhalers, eye drops, creams, and patches you take/use on a regular basis.

Start Date	Name of Medicine (brand name and generic name, if available)	Dose (mg, units, puffs, drops)	When do you take it? (morning/night, times per day, after meals, etc.)	Purpose: (why you take it)	Prescribed By: (provider name)	Additional Notes

Always refer to Healthcare Provider & Pharmacist input and the drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. When you see a Healthcare Provider, review and update this medication list.

Visit www.lchcia.com to print more "Medication List" forms.