



Medication Record Book

Knowledge is
the *best* medicine

When it comes to your health, Knowledge is the *best* medicine.

Use this booklet to record your medications, medical conditions, allergies and other health information. Keep it up to date (your doctor, pharmacist or nurse can help you) and bring it with you to medical appointments or when you go to a clinic or the hospital.

Personal Information

Name: _____

Date of Birth: _____

Blood Type: _____

Address: _____

Tel. (Home): _____

Tel. (Office): _____

Tel. (Cell): _____

Emergency Contact

Name: _____

Tel.: _____

Relationship: _____

Group Insurance

Name: _____

Tel.: _____

Contract/Policy No: _____

Personal Information (cont.)

Family Physician

Name: _____

Tel.: _____

Other Physicians

Name: _____

Specialty: _____

Tel.: _____

Name: _____

Specialty: _____

Tel.: _____

Pharmacy

Name: _____

Tel.: _____

Dentist

Name: _____

Tel.: _____

Allergies

Allergic to	Reaction

I am being treated for

Diabetes

High Blood Pressure

Heart Disease

High Cholesterol

Asthma / Breathing Problems

Arthritis

Cancer

Other:

Hospitalizations and Surgical History

Date	Physician	Hospital	Reason

Family History

Illness	Relative Affected	Comments
Diabetes		
High Blood Pressure		
Heart Disease / Heart Attacks		
High Cholesterol		
Cancer		
Other		

Medical Devices

I have/require:

Contact lenses

Eyeglasses

Hearing aid

Pacemaker

Removable dentures

Other:

Medication Record

List *all* prescription and non-prescription medications, vitamins and supplements that you take or use on a regular basis.

Medication Name	Dosage and Instructions	Reason	Prescribed by	Date	
				Start	Stop
(Example) Name of medicine	30 mg, 1 capsule twice a day, taken with food for 10 days	Pneumonia	Name of Physician	Feb 1 08	

Medication Record (cont.)

Medication Name	Dosage and Instructions		Reason	Prescribed by	Date	
					Start	Stop

10 Cross out each medicine when finished or discontinued.

Medication Record (cont.)

Medication Name	Dosage and Instructions		Reason	Prescribed by	Date	
					Start	Stop

12 Cross out each medicine when finished or discontinued.

Medication Record (cont.)

Medication Name	Dosage and Instructions		Reason	Prescribed by	Date	
					Start	Stop

Immunization Record

	Vaccine and Lot #		Date Given M/D/Y	Given by	Date Next Dose Due
MMR (measles, mumps, rubella)					
Varicella (chicken pox)					
TD (tetanus, diphtheria)					
Tdap (tetanus, diphtheria with pertussis)					
Pneumococcal					
Meningococcal					
Hepatitis B					
Hepatitis A					
HPV (human papilloma virus)					
Influenza					
Other					

Personal Notes

(Including things I should talk to my doctor or pharmacist about)

Knowledge is the *best* medicine

Ask the *questions*, get the *answers*

- What is the name of the medicine?
- Why am I taking it and what does it do?
- How do I take it?

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