Centura Health®

Name _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Prescription Medications, Vitamins and Supplements

Start date	**Medicine** Brand/generic name	**Dose** (mg, units, puffs,drops)	**When taken?** AM/PM, After meals? Times per day?	**Purpose** Why do you take it?	**Physician who prescribed**

*Always talk to your doctor and pharmacist and read the detailed drug sheets provided with each medication for a complete list of potential side effects, danger signs, and drug interactions.

	name	phone
Your Pharmacy:		
Primary Care Doctor:		
Other physicians: (specialists)		
Emergency Contact:		

Dates of last adult immunizations

Influenza _____ Pneumococcal _____ MMR _____ Tetanus/diphtheria _____

Allergies to Medicines, Foods, Environment	**Adverse Reaction Experienced** (symptoms, severity, dates)

Update this list as needed. Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list. After any hospitalization, check with your doctor to review this medication list.