My Meds. My Life.

Name: _____ Last Date Updated: _____

Date of Birth: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Primary Care Doctor: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Last Vaccination Dates: Flu: _____ Pneumonia: _____ Tetanus: _____

ALLERGIES/Reaction: _____
(Medications, latex, food, other)

MEDICATION NAME (brand or generic name, over-the-counter, herbals, vitamins, injections, eye drops, creams)	**STRENGTH** (gm, mg, cc, ml, etc.)	**HOW MANY?** (# of pills, units, puffs, drops, etc.)	**WHEN & HOW OFTEN?** (am/pm, after meals, etc.)	**REASON FOR TAKING**
Lipitor (Example)	20 mg	one tablet	once before bedtime	cholesterol

Carry this with you at all times and update every time you see a provider.

MEDICATION NAME (brand or generic name, over-the-counter, herbals, vitamins, injections, eye drops, creams)	**STRENGTH** (gm, mg, cc, ml, etc.)	**HOW MANY?** (# of pills, units, puffs, drops, etc.)	**WHEN & HOW OFTEN?** (am/pm, after meals, etc.)	**REASON FOR TAKING**
Lipitor (Example)	20 mg	one tablet	once before bedtime	cholesterol

Your Name: _____

Visit www.colorado5millionlives.org to print more forms.

This form was developed by the Colorado Foundation for Medical Care in partnership with statewide providers and stakeholders. Special thanks to The Colorado Trust's support of this project through the Colorado 5 Million Lives Campaign.