Personal Prescription Information

My Personal Information

Name ______________________________

Date of Birth ______________________________

Phone Number ______________________________

Emergency Contact

Name ______________________________

Relationship ______________________________

Phone Number ______________________________

Primary Care Physician

Name ______________________________

Phone Number ______________________________

Pharmacy/Drugstore

Pharmacist ______________________________

Phone Number ______________________________

How to Use This Form

- Keep a printed copy with you or take a photo of this form to keep on your mobile device
- Keep this form up-to-date

You should review this record when

- Starting or stopping a new medicine
- Changing a dose
- Visiting your doctor

Last Updated: ____________

Physicians

Name of Physician ______________________________

Specialty ______________________________

Phone Number ______________________________

Name of Physician ______________________________

Specialty ______________________________

Phone Number ______________________________

Name of Physician ______________________________

Specialty ______________________________

Phone Number ______________________________

My Allergies

____

____

____

My Medical Conditions

____

____

____

____

____

____

Copyright 2017 Between Sessions Resources

	What I'm taking	Form (pill, injection, liquid, patch, etc.)	Dosage	Times Taken	Use (regularly or occasionally)	Start/Stop Dates	Notes, Directions, Reasons for Use

* Be sure to include ALL prescription drugs over-the-counter drugs, vitamins, and herbal supplements.

1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Copyright 2017 Between Sessions Resources