Include Prescribed, Over the Counter, Vitamins and Herbal Medications

NAME OF DRUG	DATE (Added or changed)	STRENGTH/ DOSE	HOW MANY TIMES A DAY IT IS TAKEN	REASON FOR TAKING

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

Allergies Drug/Food/ Latex	Reaction

Pharmacy: ______________________________

Phone: ______________________________

Pharmacy: ______________________________

Phone: ______________________________

Immunization:

VACCINES	DATES GIVEN				
FLU					
PNEUMONIA					
TETANUS					

DOCTOR NAME:______________________________

SPECIALTY:______________________________

PHONE:______________________________

DOCTOR NAME:______________________________

SPECIALTY:______________________________

PHONE:______________________________

DOCTOR NAME:______________________________

SPECIALTY:______________________________

PHONE:______________________________

IN EMERGENCY CALL:

NAME: ______________________________

PHONE:______________________________

IMA Medicine Alliance, P.A.
www.imamd.com

Medication Reference Card

PATIENT NAME:______________________________

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ADDRESS:______________________________

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PHONE:______________________________

BIRTHDATE:______________________________