



# MEDICATIONS RECORD

FOR: \_\_\_\_\_ DATE: \_\_\_\_\_

Doctors and nurses will need details about any substances that could be in your loved one's system when they enter the hospital, as well as any allergies to anything. Even things taken in the recent past can still be working in your loved one's system. When it comes to cigarettes, alcohol or recreational drugs, no one will judge. Your loved one's medical team needs to know this information in order to prevent possible negative drug interactions and to be prepared for the possible effects of withdrawal.

CURRENTLY TAKING

3-6 MONTHS AGO

6+ MONTHS AGO

Medicine Name Dose & How Often	Medicine Taken For	When Taken Start / Finish	Prescribing Doctor	Taken As Ordered?
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

Cigarettes / Alcohol  
Recreational Drugs

Vitamins  
or Herbs

Non-Prescription  
Medications

Substance Name	Taken For	Usual Dose or Amount	How Often?	Last Taken?

### VACCINES

NAME	DATE	NAME	DATE

### LIST ALL ALLERGIES *(medicine, food, chemical, ingredients & environmental)*

ALLERGIC TO?	WHAT HAPPENS?