

My Medication List

A Joint Patient Safety Initiative
of the Greater Cincinnati Health
Council and area hospitals

Name: _____

Address: _____

Phone: _____

Greater Cincinnati Health Council

*If it involves health,
we're involved.*

Greater Cincinnati Health Council
2100 Sherman Avenue, Suite 100
Cincinnati, OH 45212-2775

Emergency Contact Information

Name: _____

Phone: _____

Name: _____

Phone: _____

Do You have a Living Will or
Healthcare Durable Power of
Attorney? Yes No

Are you interested in Organ
Donation? Yes No

Things you should know about your medication:

1. What are brand and generic names of the product?
2. What is the purpose of the medication?
3. What does the medication look like?
4. What is the dosage?
5. How should I take this medication?
6. How often should I take this medication? What should I do if I miss a dose?
7. Does this medication have any side effects? What are they? What should I do if they occur?
8. Does this medication interact with any other medications? Foods?
9. How should I store this medication?

Pharmacy (name, phone):

Allergies (food, medication):

Primary Care Doctor (name, phone):

**Date of last Pneumococcal
vaccine:**

Date of last Influenza vaccine:

**Recent Hospitalizations
month/year/location:**

Medical History

Please check those that apply:

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Blood Pressure |

Other: _____

Over-the Counter Medications

Check those you use regularly:

- Allergy relief, Antihistamines
- Antacids
- Aspirin/Tylenol/Ibuprofen
- Cold/Cough Medicines
- Diet Pills
- Herbs, dietary supplements
- Laxatives
- Sleeping Pills
- Vitamins or Minerals
- Other: _____

