NORTH FULTON HOSPITAL

UNIVERSAL MEDICATION FORM

Fold this form and keep it in your wallet

Date Form Started: _____

Name:	**Address:**
Phone Number:	
Birth Date:	
Emergency Contact, Name & Phone Numbers:	

Immunization Record (Record the date/year of last dose taken, if known)		
Tetanus	Flu Vaccine(s)	
Pneumonia Vaccine	Hepatitis Vaccine	Other:

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

Date you started taking this medication	Name of medication, vitamin, supplement, etc.	Dosage (located on the package)	Frequency (how often you take it)	Route (how you take it: by mouth, inhaler, injection, etc.)	Why you take this medication	Prescribing Physician	Date you stopped taking this medication

Revised 2/4/2010