2705

PERSONAL MEDICATION FORM

PROVIDENCE Health & Services

PPMC - Providence Portland Medical Center
PSVMC - Providence St. Vincent Medical Center
PMH - Providence Milwaukie Hospital

PATIENT IMPRINT

Name:______________________________ Date of birth: _________ Date form last updated: _________ Page ______

Your complete medication history is important to your physicians and to the hospital. Please fill out this form and bring it with you anytime you go to the doctor's office or to the hospital. If you are scheduled for a Pre-Surgical Services appointment, make a trip to the Emergency Room, or are coming directly to the hospital - Remember to bring this completed form! If for some reason you are unable to fill out this form, please bring in a bag of all the medications (in their original containers) that you are currently taking.

Allergies: Are you allergic to medications, iodine, food, tape, or latex?

ALLERGY & REACTION	ALLERGY & REACTION
❑ No known allergies	

Vaccines: When did you last receive these vaccines? Check one box for each vaccine.

TETANUS	PNEUMOCOCCAL (Pneumovax)	INFLUENZA (Flu)	PEDIATRIC (For child)
❑ Less than 5 years ❑ Less than 10 years ❑ Over 10 years ❑ Never ❑ Unknown	❑ Received in past (month/year) ______________ ❑ Never ❑ Unknown	❑ Date last received (month/year) ____________ ❑ Never ❑ Unknown	❑ Up-to-date ❑ Never ❑ Unknown

Medications: Please list **all** prescription and non-prescription medications, herbals, eye drops, inhalers, etc. that you use.

NAME OF MEDICINE	DOSE (mg, units, puffs)	ROUTE (by mouth, eye drops)	DIRECTIONS	PURPOSE Why do you take it?

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