Massachusetts Coalition for the Prevention of Medical Errors

MED LIST

MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

Information About You

Name ______________________________

Address ______________________________

Birth Date __________ Blood Type __________ Weight __________ Height __________

Pharmacy ______________________________ Phone __________

Primary Care Physician ______________________________ Phone __________

Other Physicians ______________________________ Phone __________

or Specialists ______________________________ Phone __________

Emergency Contact ______________________________ Phone __________

Questions to Ask Your Doctor

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Medical Conditions

☐ Asthma ☐ Heart Disease ☐ Diabetes ☐ High Blood Pressure

☐ Cancer ☐ Kidney Disease ☐ Other ______________________________

Vaccinations (please note the date of the immunization)

Influenza __________ Pneumococcal __________

MMR __________ Tetanus/Diphtheria __________

Important Health Care Documents

Location of Document

☐ Health Care Proxy ______________________________

☐ Health Care Durable Power of Attorney ______________________________

☐ Interested in Organ or Tissue Donation ______________________________

Health Insurance Plans

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Over-the-Counter Medications and Other Supplements

☐ Allergy Relief/Antihistamines

☐ Cough/Cold Medications

☐ Aspirin/Other for Pain/Headache/ Fever

☐ Antacids

☐ Laxatives

☐ Sleeping Pills

☐ Diet Pills

☐ Vitamins and Minerals

☐ Herbal/Dietary Supplements

- ☐ St. John's Wort
- ☐ Gingko Biloba
- ☐ Kava Kava

☐ Other (be sure to list on other side)

Discontinued Medications/Products (due to Allergies, Side Effects, or Reactions)

Medication/Food/Environment that cause a reaction	Allergy, Side Effects, Reaction or Intolerance Experienced (symptoms, severity)	Date (mm/yy)

MEDICATIONS Please use pencil to complete this form. **Patient Name** ________________

Start Date mm/dd/yy	Name of Medication Brand and Generic name (If available)	Prescribed By	Dosage mg/ units/ puffs/ drops	When is the Medication Taken How many times per day? Morning and/or night? After meals?	Purpose	Danger Signs* Call Immediately if you experience any of these signs	Stop Date mm/dd/yy	Monitoring Required e.g. lab test every ___ weeks	Notes/ Changes Patient Have you experienced any side effects? If stopped taking, why? Doctor Identify drugs and/or food that may cause interactions. Date list was reviewed/updated
1/01/06	*Medication ABC*	*Dr. ABC*	*5 mg*	*2 times, morning and night*	*Ulcer*			*Blood Test Every 4 weeks*	*6/15/06 – Reviewed by Dr. ABC, Changed Dosage to 10mg*

* Always refer to physician and pharmacist input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list. After any hospitalization, check with your doctor to review this medication list.