Massachusetts Coalition for the Prevention of Medical Errors

MEDICATION LIST

TUFTS Health Plan

INFORMATION ABOUT YOU

Name: _____

Address: _____

Birth Date: _____ Blood Type: _____ Weight: _____ Height: _____

Pharmacy: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Other Physicians/Specialists: _____ Phone: _____

Emergency Contact: _____ Phone: _____

QUESTIONS TO ASK YOUR DOCTOR

_____

_____

_____

_____

_____

_____

_____

MEDICAL CONDITIONS

❑ Asthma ❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure ❑ Cancer ❑ Kidney Disease

❑ Other _____

VACCINATIONS (PLEASE NOTE THE DATE OF VACCINATIONS)

Influenza: _____ Pneumococcal: _____

MMR: _____ Tetanus/Diphtheria: _____

MEDICAL CONDITIONS

❑ Health Care Proxy Location of Document: _____

❑ Health Care Durable Power of Attorney

❑ Interested in Organ or Tissue Donation

HEALTH INSURANCE PLANS

_____

_____

_____

_____

MEDICAL CONDITIONS

❑ 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 Medication list)

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	Name of Medication	Prescribed By	Dosage	When is the Medication Taken	Purpose	Danger Signs*	Stop Date	Monitoring Required	Notes/ Changes
mm/dd/yy	Brand and Generic name (If available)		mg/ units/ puffs/ drops	How many times per day? Morning and/ or night? After meals?		Call Immediately if you experience any of these signs	mm/dd/yy	e.g. lab test every ___ weeks	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.