Conditions I am being treated for:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medication allergies and sensitivities:

Medication: Type of reactions/date of reaction

_____

_____

Name _____

Medical record no. _____

Address _____

Doctor's name _____

Doctor's telephone no. _____

Pharmacist's name _____

Pharmacist's telephone no. _____

In emergency, call (name) _____

at (phone no.) _____

Personal Medication Record

UC DAVIS HEALTH SYSTEM

Prescription medications I am taking regularly or as needed (cross out if discontinued)

Date	Medication name/strength	Directions

Non-prescription medications I am taking regularly or as needed (cross out if discontinued)

Date	Medication name/strength	Directions