Choctaw Nation
Health Services Authority

MED LIST

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

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

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	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.

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