Medication Lists and Tools

First and Last Name		Date of Birth	Gender ☐ Male ☐ Female

Personal Health Number	Address	City	Province	Postal Code

Emergency Contact Name	Phone	Secondary Emergency Contact Name	Phone
Family Doctor's Name	Phone	Pharmacy Name	Phone
Specialist/Doctor's Name	Phone	Specialist/Doctor's Name	Phone

Benefits/Medical Plan Name and # (e.g. Alberta Blue Cross)

Medical History ☐ Diabetes ☐ High blood pressure ☐ Heart conditions ☐ Breathing problems	☐ Other medical history:

Allergies *(The following is a list of* ***medications*** *I am* ***allergic*** *to, and what happens when I take them)* ☐ No medication allergies

This List belongs to	Created on

Name of Medication	Dose/ Strength	How Much	How Often/When: Morning	Afternoon	Evening	Bedtime	As Needed	Why I take it	Additional Information	Date
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