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					Why I take it	Additional Information	Date
			Morning	Afternoon	Evening	Bedtime	As Needed			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			