KEEP IN YOUR WALLET

Personal Medicine List

Carrying a list of all the medicines you take may save your life.

PERSONAL RECORD

Blood Tests

Date _____

HbA_1C _____

Cholesterol:

Total _____

LDL _____

HDL _____

Date	Weight	Blood Pressure
TARGET		

Developed by: UVA Health System,
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Rehabilitation Hospital | INFO90025 3/09

HOW TO USE THIS CARD

1. **List all medicines** you take. This includes any without a prescription, eye drops, skin patches, vitamins, herbals, birth control, etc.
2. **Use a pencil** so you can make changes.
3. **Keep the card up-to-date**. If you or your doctors make any changes, add or take away any medicine, change the list.
4. **Take the card** with you anytime you go to a hospital, clinic, or doctor.

ALSO

✓ Check refill dates on the prescription label so you don't runout of medicines.

✓ Ask your doctor, nurse, or pharmacist to help you learn more about your medicines and how to take them safely.

SIGNS OF A HEART ATTACK

- Chest pain or discomfort, which can last more than a few minutes, or it can go away and come back. It feels like uncomfortable pressure, squeezing, fullness or pain.
- Pain or discomfort in other areas of the upper body including the arm(s), back, neck, jaw, or stomach.
- Shortness of breath.
- Breaking out in a cold sweat, nausea/vomiting or lightheadedness.

If you experience any of the signs of a heart attack, call 911 right away.

SIGNS OF STROKE

Sudden onset of :

- Numbness or weakness of the face, arm or leg (especially on one side of the body)
- Trouble speaking or understanding speech, confusion
- Trouble seeing out of one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

If you experience any of the signs of stroke, call 911 right away.

ALLERGY INFORMATION

List any allergies or problems you have with medicines, foods, latex, etc. and what happens to you when you take or use them.

Medicine/Drug

_____

_____

_____

_____

_____

Food or other allergies

_____

_____

_____

_____

IMPORTANT NUMBERS

NAME PHONE

Family Doctor

_____ _____

Other Doctors/Providers

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Prescriptions filled at

_____ _____

Emergency Contact

_____ _____

Relationship

_____

Other Contact

_____ _____

Name_____ Date of Birth _____ Phone (_____) _____

Vaccination Dates: Flu _____ Pneumonia_____ Tetanus_____ Other_____

Medicines I take - *including those without a prescription: over-the-counter, vitamins, supplements, herbals, eye-drops, patches, etc.*

MEDICINE NAME / STRENGTH Example: Senicidem 40 mg	**HOW MUCH / WHEN I TAKE IT** Example: 2 tablets twice a day with meals	**WHAT I TAKE IT FOR** Example: Blood Pressure	**OTHER INFORMATION** Example: Get bloodwork monthly

Date updated: _____ _____ _____

Bring all medicines you take to every health care visit (including those without a prescription)