

## NON-PRESCRIPTION MEDICATIONS

Complete both sides of card.  
Please check any of the  
following medications  
you currently use.

- Aspirin
- Over-the-counter  
pain medication
- Antacids/Laxatives

List your vitamins and  
herbal supplements:

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Drug allergies:

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## VACCINATIONS

Influenza:

date: \_\_\_\_\_

date: \_\_\_\_\_

Pneumococcal:

date: \_\_\_\_\_

date: \_\_\_\_\_

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## MY MEDICATION TRACKER

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

