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:

_____

_____

_____

_____

_____

Drug allergies:

_____

_____

_____

_____

VACCINATIONS

Influenza:

date: _____

date: _____

Pneumococcal:

date: _____

date: _____

_____

_____

_____

MY MEDICATION TRACKER

Name: _____

Phone: _____

Emergency Contact: _____

Emergency phone: _____

Pharmacy: _____

MEMORIAL

YAKIMA VALLEY MEMORIAL HOSPITAL

Medication	Strength	Directions for Use	Date Prescribed	Reason for Taking

Primary Care Physician:_____ **Phone:**_____