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
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			
			☐	☐	☐	☐	☐			