Personal Medication Organizer

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METHODIST HOSPITAL

"Committed to Safety"

Patient Information

Patient Name _____DOB_____
Address_____
_____
Telephone #: ( ) _____
Emergency Contact: (NAME/PHONE)_____
_____
Drug/Food Allergies:_____
Vaccination Status: Pneumo _____ Flu _____

Health Care Provider Information:

Primary Physician: _____Phone #:_____
Address: _____
Specialist(s):_____Phone #:_____
Address: _____
Pharmacy: _____Phone #:_____
Address: _____

Drug (Trade and generic) and over-the-counter product name	Prescribing Physician	Strength (Dosage)	How many times a day and at what time during the day do you take this prescription?	What liquid/food should or shouldn't you talk with this medication? Other special instructions?