Conditions I am being treated for:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medication Allergies & Sensitivities

Medication & Type of Reactions/Date of Reaction

_____
_____
_____
_____
_____

Name_____
Medical Record No. _____
Address_____

_____
Doctor's Name_____
Doctor's Telephone No. _____
Pharmacy Name _____
Pharmacy Telephone No. _____
For Emergencies (Name) _____
At (Phone No.)_____

STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

Personal Medication Card

100-1052 (9/05)

Medications I am taking regularly or as needed (i.e., prescription, herbals, etc.)

Cross out if discontinued

Start Date	Medication Name/Strength	Directions

Immunizations

Date of last Flu vaccine:

Date of last Pneumovax:

Date of last Tetanus:

ALWAYS KEEP THIS CARD WITH YOU.

How does this card help you?

- **Improves MEDICATION SAFETY**
- **Improves communication**