My Health Record

Keep this record updated any time your doctor's information or your prescribed medication, dosage, or frequency changes. Keep a copy in your emergency kit. Always take your medication list to doctor's visits and to the hospital. Check the box below and complete the other side if you take more than three medications.

Name: _____ **Date:** _____ **By:** _____

Physician: _____ **Phone:** _____ **Specialty:** _____

Physician: _____ **Phone:** _____ **Specialty:** _____

Physician: _____ **Phone:** _____ **Specialty:** _____

Emergency Contact Name/Phone Number: _____

Allergies (Food, Medication, Latex, etc.): _____

Medical History: (Include Diagnoses and Conditions: _____

_____

_____

List Other Medical Devices (such as Pacemaker, IV or Dialysis Ports, etc.) _____

_____

Medication Include name brand and generic name, if applicable, include oxygen, and other treatments or wound care	**Dosage** List the amount of each dose (e.g., # mg)	**Frequency/ Time** How many times per day medication is taken and at what time	**Diagnosis or reason this medication is taken**	**Notes** Include if this medication should be taken with food, taken on an empty stomach, or other special instructions

☐ **Record continues on back**

Continued from other side

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Home Health • Private Duty
Home Medical Equipment

MARYLAND EMERGENCY PREPAREDNESS NETWORK
Helping Maryland's Most Vulnerable

MARYLAND Department of Health
Office of Preparedness and Response

Provided in partnership by the Maryland Department of Health Office of Preparedness and Response and the Maryland-National Capital Homecare Association