I take the following non-prescription medications:

- ❑ Cough or cold medicine
- ❑ Aspirin or other pain medicine
- ❑ Allergy relief medicine
- ❑ Antacids
- ❑ Sleeping pills
- ❑ Laxatives
- ❑ Other

List:

Medication name and dose	How often I take it

I take the following vitamins, herbals and supplements:

- ❑ Vitamins _____
  _____
- ❑ Herbal supplements _____
  _____
- ❑ Other supplements _____
  _____

I have had the following vaccinations:

❑ **Flu shot**	**Date:**
❑ **Pneumonia**	**Date:**
❑ **Tetanus**	**Date:**
❑ **Hepatitis**	**Date:**
❑ **Other:**	**Date:**
❑ **Other:**	**Date:**

UNIVERSITY OF OTTAWA
HEART INSTITUTE

INSTITUT DE CARDIOLOGIE
DE L'UNIVERSITÉ D'OTTAWA

MEDICATION RECORD

Name: _____

Phone: _____

Cell phone: _____

HEA 166 (08/2009) TRIAL

My prescription medications

Name and dose of medication	When it is taken	Date started	What is it taken for	Prescribing Doctor	Renewal date

My pharmacy name and phone number:

_____

In case of emergency, please contact:

Name:

_____

Phone:

_____

Cell phone:

_____

My allergies:

_____

_____

I have the following health conditions:

_____

_____