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:

<table>
<thead>
<tr>
<th>Medication name and dose</th>
<th>How often I take it</th>
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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:
<table>
<thead>
<tr>
<th>Name and dose of medication</th>
<th>When it is taken</th>
<th>Date started</th>
<th>What is it taken for</th>
<th>Prescribing Doctor</th>
<th>Renewal date</th>
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**My pharmacy name and phone number:**
______________________________

**In case of emergency, please contact:**
Name: _______________________
Phone: _______________________
Cell phone: ___________________

**My allergies:**
____________________________

**I have the following health conditions:**
____________________________