Massachusetts Coalition for the Prevention of Medical Errors

NBH
NORTHERN BERKSHIRE HEALTHCARE

MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

MEDLIST

Information About You

Name ____________________

Address ____________________

Birth Date __________ Blood Type __________ Weight __________ Height __________

Pharmacy ____________________ Phone __________

Primary Care Physician ____________________ Phone __________

Other Physicians ____________________ Phone __________

or Specialists ____________________ Phone __________

Emergency Contact ____________________ Phone __________

Questions to Ask Your Doctor

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Medical Conditions

- ☐ Asthma
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Other ____________________

Vaccinations (please note the date of the immunization)

Influenza __________ Pneumococcal __________

MMR __________ Tetanus/Diphtheria __________

Important Health Care Documents

Location of Document

- ☐ Health Care Proxy ____________________
- ☐ Health Care Durable Power of Attorney ____________________
- ☐ Interested in Organ or Tissue Donation ____________________

Health Insurance Plans

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Over-the-Counter Medications and Other Supplements

Discontinued Medications/Products (due to Allergies, Side Effects, or Reactions)

- ☐ Allergy Relief/Antihistamines
- ☐ Cough/Cold Medications
- ☐ Aspirin/Other for Pain/Headache/ Fever
- ☐ Antacids
- ☐ Laxatives
- ☐ Sleeping Pills
- ☐ Diet Pills
- ☐ Vitamins and Minerals
- ☐ Herbal/Dietary Supplements
  - ☐ St. John's Wort
  - ☐ Gingko Biloba
  - ☐ Kava Kava
- ☐ Other (be sure to list on other side)

Medication/Food/Environment that cause a reaction	Allergy, Side Effects, Reaction or Intolerance Experienced (symptoms, severity)	Date (mm/yy)

MEDICATIONS Please use pencil to complete this form. **Patient Name** ______________________________

Start Date	Name of Medication	Prescribed By	Dosage	When is the Medication Taken	Purpose	Danger Signs*	Stop Date	Monitoring Required	Notes/ Changes
mm/dd/yy	Brand and Generic name (If available)		mg/ units/ puffs/ drops	How many times per day? Morning and/or night? After meals?		Call Immediately if you experience any of these signs	mm/dd/yy	e.g. lab test every ___ weeks	Patient Have you experienced any side effects? If stopped taking, why? Doctor Identify drugs and/or food that may cause interactions. Date list was reviewed/updated
1/01/06	*Medication ABC*	*Dr. ABC*	*5 mg*	*2 times, morning and night*	*Ulcer*			*Blood Test Every 4 weeks*	*6/15/06 – Reviewed by Dr. ABC, Changed Dosage to 10mg*

* Always refer to physician and pharmacist input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list. After any hospitalization, check with your doctor to review this medication list.