A.G. CICCAGLIONE, M.D.
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Information about you

Your name: _____

Address: _____

Birth Date: _____ Blood Type: _____ Weight: _____ Height: _____

	name	*phone*
Pharmacy:	_____	_____
Primary care doctor:	_____	_____
Other physicians:	_____	_____
(specialists)	_____	_____
Emergency Contact:	_____	_____

Comments About My Health

Surgeries: _____

Medical Conditions

☐ asthma ☐ heart disease ☐ diabetes ☐ high blood pressure

☐ cancer ☐ kidney disease ☐ other _____

Vaccinations

Influenza: _____
Pneumococcal: _____
MMR: _____
Tetanus/Diphtheria: _____

Over-the-Counter Medications

(Remember to write on other side.)

☐ Allergy relief, antihistamines
☐ Antacids
☐ Aspirin/other pain, headache, or fever
☐ Arthritis medications
☐ Cold/cough medications
☐ Diet pills
☐ Herbals, dietary supplements
☐ Laxatives ☐ Others (list below):
☐ Sleeping pills
☐ Vitamins, minerals

Allergies or Sensitivities

Medication, Food, Environmental	Allergy, Side Effects, Reaction or Intolerance Experiences (symptoms, severity, dates)

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Start Date	**Name of Medicine** Brand name Generic name too if available	**Prescribed By**	**Dose** (mg, units, puffs, drops)	**When Do You Take It?** How many times per day? Morning and night? After meals? With meals?	**Purpose** Why do you take it?	**Important Comments** (e.g. danger signs, side effects, drug-drug, food-drug interactions, stopped taking*)	**Stop Date**	**Monitoring Required** (e.g. lab test every ____ weeks)	**Notes** Date Reviewed; Date Updated

*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.

USE PENCIL Whenever you see a doctor, including your primary care physician and any specialists, **review and update this medication list.**