# HOW TO USE THIS CARD

1. **List all medicines** you take. This includes any without a prescription, eye drops, skin patches, vitamins, herbals, birth control, etc.
2. **Use a pencil** so you can make changes.
3. **Keep the card up-to-date**. If you or your doctors make any changes, add or take away any medicine, change the list.
4. **Take the card** with you anytime you go to a hospital, clinic, or doctor.

**ALSO**

- ✓ Check refill dates on the prescription label so you don't runout of medicines.
- ✓ Ask your doctor, nurse, or pharmacist to help you learn more about your medicines and how to take them safely.

## SIGNS OF A HEART ATTACK

- Chest pain or discomfort, which can last more than a few minutes, or it can go away and come back. It feels like uncomfortable pressure, squeezing, fullness or pain.
- Pain or discomfort in other areas of the upper body including the arm(s), back, neck, jaw, or stomach.
- Shortness of breath.
- Breaking out in a cold sweat, nausea/vomiting or lightheadedness.

*If you experience any of the signs of a heart attack, call 911 right away.*

## SIGNS OF STROKE

*Sudden onset of :*

- Numbness or weakness of the face, arm or leg (especially on one side of the body)
- Trouble speaking or understanding speech, confusion
- Trouble seeing out of one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

*If you experience any of the signs of stroke, call 911 right away.*

## ALLERGY INFORMATION

List any allergies or problems you have with medicines, foods, latex, etc. and what happens to you when you take or use them.

Medicine/Drug

Food or other allergies

## IMPORTANT NUMBERS

NAME PHONE

Family Doctor

Other Doctors/Providers

Prescriptions filled at

Emergency Contact

Relationship

Other Contact

## PERSONAL RECORD

*Blood Tests*

Date

$HbA_1C$

Cholesterol:

Total

LDL

HDL

| Date | Weight | Blood Pressure |
|---|---|---|
| **TARGET** | | |
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Developed by: UVA Health System, Martha Jefferson Hospital & UVA Health-South Rehabilitation Hospital | INFO90025 3/09

## KEEP IN YOUR WALLET

# Personal Medicine List



*Carrying a list of all the medicines you take may save your life.*

Name_____ Date of Birth _____ Phone (_____) _____

Vaccination Dates: Flu _____ Pneumonia_____ Tetanus_____ Other_____

**Medicines I take -** *including those without a prescription: over-the-counter, vitamins, supplements, herbals, eye-drops, patches, etc.*

| **MEDICINE NAME / STRENGTH**<br>Example: Senicidem 40 mg | **HOW MUCH / WHEN I TAKE IT**<br>Example: 2 tablets twice a day with meals | **WHAT I TAKE IT FOR**<br>Example: Blood Pressure | **OTHER INFORMATION**<br>Example: Get bloodwork monthly |
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**Date updated:** _____ _____ _____

**Bring all medicines you take to every health care visit (including those without a prescription)**