Keep at hand

My Medical Record

Keep your record and your family members' records current*.
Bring the record with you to medical appointments.

Personal Information

Name: ______________________________

Date of birth: ______________________________

Address: ______________________________

Home phone #: ______________________________

Cell phone #: ______________________________

Office phone #: ______________________________

Email: ______________________________

Emergency contact

Name: ______________________________

Phone: ______________________________

Health insurance (RAMQ)

Health insurance card #: ______________________________

Expires on: ______________________________

Private insurance: ______________________________

Client #: ______________________________

My doctor

Name: ______________________________

Phone: ______________________________

Clinic address: ______________________________

* As needed, photocopy this form and fill one out for each person.

My pharmacy

Health problems:

Diabetes | Hypertension | Cardiac insufficiency

COPD, asthma | Renal insufficiency

Name of my pharmacy: ______________________________

Address of my pharmacy: ______________________________

Phone # of my pharmacy: ______________________________

Allergies to one or more medications:

Food allergies

Eggs | Peanuts | Nuts

Others:

Immunisations

Influenza (flu) vaccine Date : ______________________________

Pneumococcus vaccine Date : ______________________________

Others:

Medication profile

Ask your pharmacist to print out your medication profile or fill out this form*.

Name: ______________________________

Date of birth: ______________ Date of last update: ______________

Medication 1

Name of medication: ______________________________

Dosage (e.g. 100 mg, 5 mg/ml): ______________________________

Frequency (e.g. 1 pill at bedtime): ______________________________

Medication 2

Name of medication: ______________________________

Dosage (e.g. 100 mg, 5 mg/ml): ______________________________

Frequency (e.g. 1 pill at bedtime): ______________________________

Medication 3

Name of medication: ______________________________

Dosage (e.g. 100 mg, 5 mg/ml): ______________________________

Frequency (e.g. 1 pill at bedtime): ______________________________

Medication 4

Name of medication: ______________________________

Dosage (e.g. 100 mg, 5 mg/ml): ______________________________

Frequency (e.g. 1 pill at bedtime): ______________________________

Medication 5

Name of medication: ______________________________

Dosage (e.g. 100 mg, 5 mg/ml): ______________________________

Frequency (e.g. 1 pill at bedtime): ______________________________

Medication 6

Name of medication: ______________________________

Dosage (e.g. 100 mg, 5 mg/ml): ______________________________

Frequency (e.g. 1 pill at bedtime): ______________________________

* If you have more than 6 medications to take daily, please attach a second sheet to your medical record.