MY MEDICATIONS

Medication Name	Dose	How Often?	Reason	Prescribed By

MEDICATION RECORD

Pharmacy Name

Pharmacy Phone Number

Date Updated

Bryan HEALTH CONNECT

My Personal Information

Name:

Date of Birth:

Address:

Phone:

Emergency Contact Name:

Emergency Contact Phone Number:

Primary Care Provider:

Office Phone Number:

Care Team:
Specialists/Other Providers

Provider 1:

Office Phone Number:

Provider 2:

Office Phone #:

My Medical History

Allergies:

My medical conditions are:

- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Asthma/COPD
- ☐ Pacemaker/Defibrillator
- ☐ Blood Thinners
- ☐ _____
- ☐ _____
- ☐ _____

My Health Care Maintenance

	Date	Location
Colonoscopy		
Mammogram		
DEXA scan		
Shingles vaccine		
Pneumonia vaccine		
Influenza vaccine		
Tdap vaccine		
Tetanus (TD) vaccine		