

Please use this form to keep you and your healthcare providers updated on any prescriptions, herbals, vitamins and over-the-counter medications you are taking.

### In Case of Emergency Contact

Name: \_\_\_\_\_  
 \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_

*Taking an active role in your care can help prevent medication errors.*



# Medication Card



Carolinus Medical Center  
NorthEast

*Uncompromising Excellence. Commitment to Care.*

920 Church St., North • Concord, NC

800-575-1275 or 704-403-1275

[www.cmc-northeast.org](http://www.cmc-northeast.org)



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NorthEast

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I have a living will.  Yes  No

On file at CMC-NorthEast  Yes  No

Healthcare Power of Attorney  Yes  No

Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 \_\_\_\_\_

### Advanced Directives

Fill in medication name and type of allergy: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Allergies

Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 \_\_\_\_\_  
 Mail Order Pharmacy  Yes  No  
 Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 \_\_\_\_\_

### My Pharmacy

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_

### Medication List Updated

### Vaccinations

Fill in most recent date. \_\_\_\_\_  
 Influenza (Flu)  
 Pneumovax  
 Tetanus/Diphtheria/Pertussis  
 Hepatitis A  
 Hepatitis B  
 Zostavax

