

Lexington Medical Park 3 155 North Hospital Drive, Suite 300 West Columbia, SC 29169

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LexingtonWomensCare.com



Universal Medication Form						
Name:				Date form started:		
Birth Date:				Emergency Contacts (name and number)		
Address:				1	(	)
Phone Number:				2		)
IMMUNIZATION RECORD (Record the date/year of the last dose taken, if known)						
			Flu Vaccine(s) Other			
		. ,				
Allergic To		Describe Reaction		Allergic To	Des	cribe Reaction
LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerin).						
DATE	Na	ame of Medication and Dose	Use patient fi	CTIONS: riendly directions. dical abbreviations.)	DATE STOPPED	NOTES: Reason for taking and Doctors Name