Integrative Medication JOURNAL

Integrative Medication Journal

1. This journal was created to ensure your safety and as a medication error prevention tool. YOU own this information!

2. **ALWAYS KEEP YOUR JOURNAL CURRENT**!

3. Record any new medications added. Include any new supplements/vitamins, over-the-counter medications, herbals and homeopathic preparations you start taking.

4. If you have a medication, supplement/vitamin, over-the-counter medication, herbal or homeopathic preparation STOPPED by your provider, be sure to update this change to your Integrative Medication Journal. Draw a line through the medication that was stopped and *record the date it was stopped.*

5. Have this information readily available for consultations with other healthcare providers and in the event you are admitted to the hospital.

6. If you are admitted to the hospital, be sure your journal is modified upon discharge.

7. Upon initial completion of your Integrative Medication Journal, secure all original documents in a safe place where you AND a loved one can readily access. It is very important another person knows where to find your medication journal! Be sure to provide your physician with a copy of this information to assure he has a thorough, complete and updated medication list available in his office. Do not automatically assume your physician knows all of the medications you are taking. YOU are responsible for knowing everything you take!

Medication History Form

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone Number:	

Immunizations:

Tetanus	Pneumonia	Influenza (Flu)	Pediatric (child)
☐Within past 10 years ☐Unknown	☐Within past 5 years ☐Unknown	☐Within past year ☐Unknown	☐Up-to-date ☐Unknown

Allergies:

1. Medications, Supplements, Food, Iodine, Tape, Latex
2. Allergic reaction/intolerance patient experienced

Allergy	Reaction/Intolerance
1.	
2.	
3.	
4.	
5.	

Medication List Review and Update Log:

Reviewed on:	Reviewed by:	Updated on:	Updated by:

Medication History:

1. Prolonged or regular use of NSAIDS (Ibuprofen, Naproxen, Aspirin, etc.)
   - ☐ YES: _____
   - ☐ NO
2. Prolonged or regular use of Tylenol/acetaminophen?
   - ☐ YES: _____
   - ☐ NO
3. Prolonged or regular use of Acid Blocking Drugs (H2, PPI, etc.)?
   - ☐ YES: _____
   - ☐ NO
4. Frequent use of antibiotics >3 times/year?
   - ☐ YES: _____
   - ☐ NO
5. Long-term use of antibiotics?
   - ☐ YES: _____
   - ☐ NO
6. Use of steroids (prednisone, nasal allergy inhalers) in the past?
   - ☐ YES: _____
   - ☐ NO
7. Use of oral contraceptives?
   - ☐ YES: _____
   - ☐ NO

Medical Contact Information:

MD:	Phone:
Naturopath:	Phone:
Nutritionist:	Phone:
Pharmacy:	Phone:
Pharmacist:	Phone:

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Notes

MY MEDICATION LIST:

RX, OTC, Herbals, Nutritional Supplements/Vitamins, Medicinal Food, Homeopathy

NAME: _____ **DOB:** _____ **Page _____ of _____**

MEDICATION (RX/OTC)	Dose	Route	Frequency	Timing of Doses							PURPOSE
				On Rising	Breakfast	Mid-Morning	Lunch	Mid-Afternoon	Dinner	Before Bed	

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MY SUPPLEMENT LIST:

RX, OTC, Herbals, Nutritional Supplements/Vitamins, Medicinal Food, Homeopathy

NAME: _____ **DOB:** _____ **Page** _____ **of** _____

Supplement, Vitamin, Herbal, Homeopathy	Dose	Route	Frequency	Timing of Doses							PURPOSE
				On Rising	Breakfast	Mid-Morning	Lunch	Mid-Afternoon	Dinner	Before Bed	

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