



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!



Heal
Yourself
Beautiful®

Medication History Form

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

Immunizations:

Tetanus	Pneumonia	Influenza (Flu)	Pediatric (child)
<input type="checkbox"/> Within past 10 years	<input type="checkbox"/> Within past 5 years	<input type="checkbox"/> Within past year	<input type="checkbox"/> Up-to-date
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> 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:



Notes



A series of 20 horizontal black lines providing a space for writing 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	



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
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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	



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
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