

## Over-the-Counter Medicines

(check all that you use regularly)

- Allergy Relief Medicine
  - Antacids
  - Aspirin/Other Pain, Headache or Fever Medicine
  - Cold Medicine
  - Cough Medicine
  - Diet Pills
  - Laxatives
  - Herbal Supplements
  - Sleeping Pills
  - Vitamins
  - Others (list below)
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## Remember to ask

your pharmacists, doctors or other health care providers:

- 1** What is the name of the medicine and what is it supposed to do?
- 2** Is this the brand name or generic name: How and when do I take it and for how long?
- 3** Are there any monitoring tests required with this medicine (for example, to check liver or kidney functions)?
- 4** What foods, drinks, other medicines or activities should I avoid while taking this medicine?
- 5** What are the possible side effects, and what do I do if they occur?
- 6** Will this new prescription work safely with the other prescription and non-prescription medicines I am taking?
- 7** Is there any written information available about the medicine? (In large print, or in a language other than English?)



## Medication Wallet Card

### BeMedWise Program at NeedyMeds

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PO Box 219  
Gloucester, MA 01931  
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email: [info@bemedwise.org](mailto:info@bemedwise.org)

[www.bemedwise.org](http://www.bemedwise.org)

# Personal Medical Data

Please write in pencil

My name is \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## I am allergic to (please check):

- |  |                                       |                                      |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin         | <input type="checkbox"/> Insect Bites | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Other Medicines | <input type="checkbox"/> Food         | <input type="checkbox"/> Codeine     |

## My medical condition includes:

- |                                       |                                     |   |  |
|---------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Depression | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Angina       | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Heart Condition    | <input type="checkbox"/> Pace Maker          |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Hemodialysis       | <input type="checkbox"/> Visual Impairment   |
| <input type="checkbox"/> Other        |                                     |   |  |

Doctor's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Pharmacist's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## Notify in Emergency:

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## All Medicines I am Taking:

Prescription:

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If you have questions about  
specific medicines, visit  
[www.medlineplus.gov](http://www.medlineplus.gov)

(Please list your non-prescription  
medicines on the reverse side.)