



Banner Health[®]

Banner Medications Form

(always keep this form with you)

Name: _____ Date Completed: _____

Preferred Pharmacy / Phone: _____

Address: _____

Phone Number: _____ Birth Date: _____

Emergency Contact / Phone: _____

Allergies & Drugs to Avoid / Adverse Reactions: _____

Current Medications:

(List all medications you are taking, include over-the-counter (e.g., aspirin, antacids, vitamins and herbals))

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

(continued on other side)

Current Medications Continued:

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Doctor: _____ Date Started: _____

Immunization Record (Include dates administered):

Tetanus: _____ Pneumonia Vaccine: _____ Flu Vaccine: _____

Hepatitis B Vaccine: _____ Other: _____ Other: _____

Other: _____ Other: _____ Other: _____