☐ Health Care Proxy ☐ Other		
Health Insurance Plans		
Plan Name	Policy Number	
Plan Name	Policy Number	
Allergies, Side Effects, (or Reactions	
Medication/Food/Environment that causes reaction	Allergy, Side Effects, Reaction or Intolerance Experienced (symptoms, severity)	Date of Event (mm/yy)
	I	
Over-the-Counter Medic	cations and other Supplements	
	Antacids ☐ Aspirin/Other for Pain/Headache/Fe	ver 📮 Diet Pill
☐ Cough/Cold Medications	☐ Vitamins/Minerals ☐ Laxatives ☐ Sleeping F	Pills 🖵 Fish Oil
☐ Herbal/Dietary O Suppleme	ents O St. John's Wort O Gingko Biloba O Ka	ava Kava
Other (please list)		

Get Med Smart

Get Med Smart is a service provided by Lowell General Hospital

For help with completing this form or to download a new document, please visit our website at www.lowellgeneral.org

Name				
Address				
Birth Date	Blood Type	Weight	Height	

Medical Contacts

Pharmacy	Phone	
Primary Care Physician	Phone	
Other Physicians/Specialists	Phone	
	Phone	
_	Phone	
Emergency Contact	Phone	

Medical Conditions

Kidney Disease	☐ Heart Disease	☐ Medical Devices	☐ High Blood Pressure
☐ Asthma	☐ Cancer	☐ Diabetes	
☐ Other (please list)			

Vaccinations (please note the date of the immunizations)

Influenza	Pneumococcal		
MMR	Tetanus/Diphtheria		

My Medication List Please use pencil to complete this form

	Start Date	Name of Medication	Prescribed by	Dosage	When is the Medication Taken?	Purpose	Danger Signs*	Stop Date	Monitoring Required	Notes/Changes
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

1. Always keep this form with you.

- 2. Take this form to ALL doctor visits, ALL medical testing (lab, x-ray, MRI, CT, etc.) pre-assessment visits for admission or surgery, and ALL hospital visits (ER, in-patient admission, out-patient visits)
- 3. Update this form with medication changes. If a medication is stopped, draw a line through it and record the date it was stopped. If you need help filling out this form, ask a physician, nurse, pharmacist, friend or family member.
- 4. In the NOTES/CHANGES column, record things like the name of the doctor who told you to take this medication. You may also add the reason for taking the medication (high blood pressure, nerves, sleep...). Always keep this form with you.
- 5. Tell your family, friends and neighbors about the benefits of using this form.
- 6. When you are discharged from the hospital, update your form. When you return to your primary care physician or see a specialist, take your updated form with you. Always keep this this form with you. This will keep everyone up-to-date on your medications.

*Refer to physician input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. After any hospitalization, check with your doctor to review this medication list. For assistance visit www.lowellgeneral.org or call 1-877-LGH-WELL (1-877-544-8355).





A CIRCLE HEALTH MEMBER

Complete connected care^{ss}