Med-Check Passport

Bring it to every doctor or pharmacy visit

You will write down a list of all the medications that you are taking, how you take them, how much, and how often.
(Include the medications you buy over-the-counter, herbals, vitamins, supplements, etc.)

Your doctor or pharmacist will review them to properly take care of you.

Talk to your doctor or pharmacist if you have any questions about your medications

Med-Check Passport

Name:_____

Telephone number:_____

Pharmacy:_____

Doctor:_____

Do you have any allergies (list all)?

_____

_____

This material was prepared by the Delmarva Foundation for Medical Care (DFMC), the Disparities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy 10SOW-MD-DNCC-071114-558. The MedCheck Passport is a tool developed in partnership by the University of Maryland Eastern Shore (UMES) School of Pharmacy and the Primary Care Coalition (PCC) of Montgomery County. This tool is provided to you for your own personal use to keep record of your medications. You can print it and report it to your doctor and pharmacist at every visit to help better manage your medications. This form does not replace talking with your doctor or pharmacist. Delmarva, PCC, and UMES do not retain your records and are not responsible for the accuracy of the information included or for the current status of your personal medications.

Med-Check Passport (Notes)

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Patient Name:

Vaccinations (MM/YY): ☐ Influenza (Flu Shot): ___/___ ☐ Pneumococcal: ___/___ ☐ Other ________________________________: ___/___







Medication Name	What are you taking it for?	Dose	How do you take it?	When do you take it? (Check all that applies)	Special Instructions	Change (Please explain)	Which Pharmacy do you use?
			☐ By Mouth ☐ Injection ☐ Other:____	☐ Morning ☐ Noon ☐ Evening ☐ Bedtime ☐ Other:____		☐ Stopped taking medicine ☐ Changed directions Date: ________________ Explain: ______________	
			☐ By Mouth ☐ Injection ☐ Other:____	☐ Morning ☐ Noon ☐ Evening ☐ Bedtime ☐ Other:____		☐ Stopped taking medicine ☐ Changed directions Date: ________________ Explain: ______________	
			☐ By Mouth ☐ Injection ☐ Other:____	☐ Morning ☐ Noon ☐ Evening ☐ Bedtime ☐ Other:____		☐ Stopped taking medicine ☐ Changed directions Date: ________________ Explain: ______________	
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  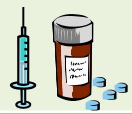    

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