

Working with our doctors as treatment partners!

Medications Workbook



MyMigraineConnection.com

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The HealthCentral Network

www.MyMigraineConnection.com

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Medications can be a vital part of feeling and living well.

Use this workbook to track what medications you've tried and how they did for you and what medications you're currently taking.

There are also sheets for basic personal information and a basic medical history.

Completed copies of these forms can be very helpful to you and your doctors.

Basic Personal Information

Personal Contact Information

Name: _____

Birth Date: _____

Street Address: _____

City: _____

State, Zip Code: _____

Home Phone Number: _____

Office Phone Number: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Primary Care Physician:

Name: _____

Phone Number: _____

Other Physician:

Name: _____

Phone Number: _____

Specialty: _____

Pharmacy:

Name/Location: _____

Phone Number: _____

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Allergic Reactions or Problems With...

(medications, dietary supplements, foods, tape...)

Surgeries, Medical Conditions:

Medical Insurance Information:

Name on Policy: _____

Insurance Company: _____

Plan/Group #: _____

ID #: _____

Phone Number: _____

Medical History Checklist

Name: _____

Today's Date: _____

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Date of Birth: _____

Previous Illnesses: Have you ever had any of the following?

	Yes	No
Allergies	_____	_____
Anemia	_____	_____
Anxiety	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Bleeding/clotting disorders	_____	_____
Blood transfusion	_____	_____
Bronchitis	_____	_____
Cancer	_____	_____
Depression	_____	_____
Diabetes	_____	_____
Emphysema	_____	_____
Headaches	_____	_____
Heart disease	_____	_____
Hepatitis	_____	_____
High blood pressure	_____	_____
Infections	_____	_____
Kidney disease	_____	_____
Meningitis	_____	_____
Menstrual problems	_____	_____
Migraines	_____	_____
Mononucleosis	_____	_____
Pneumonia	_____	_____
Rheumatic fever	_____	_____
Scarlet fever	_____	_____
Seizures	_____	_____
Sinusitis	_____	_____
Sleep problems	_____	_____
Stroke	_____	_____
Thyroid problems	_____	_____
Tuberculosis	_____	_____
Ulcer	_____	_____
Vision/eye problems	_____	_____

Do you have a family history of any of the following?

	Yes	No
Anemia	_____	_____
Anxiety	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Bronchitis	_____	_____
Cancer	_____	_____
Depression	_____	_____
Diabetes	_____	_____
Emphysema	_____	_____
Headaches	_____	_____
Heart disease	_____	_____
Hepatitis	_____	_____
High blood pressure	_____	_____
Kidney disease	_____	_____
Migraines	_____	_____
Seizures	_____	_____
Stroke	_____	_____
Thyroid problems	_____	_____

Immunizations:

Flu shot	_____	_____
Chicken pox	_____	_____
HPV	_____	_____
Measles	_____	_____
Pneumonia	_____	_____
Polio	_____	_____
Tetanus	_____	_____
Other:	_____	

Medical History Checklist

Name: _____

Today's Date: _____

Surgeries:

	Yes	No
Breast	_____	_____
C Section	_____	_____
Gallbladder	_____	_____
Heart	_____	_____
Hernia	_____	_____
Kidney	_____	_____
Nose/Sinus	_____	_____
Ovaries	_____	_____
Prostate	_____	_____
Thyroid	_____	_____
Tonsils	_____	_____
Uterus	_____	_____

Other: _____

Allergies:

Foods: _____

Medications: _____

Other: _____

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Date of Birth: _____

Injuries:

	Yes	No
Abdomen	_____	_____
Back	_____	_____
Broken bones	_____	_____
Chest	_____	_____
Head	_____	_____
Neck	_____	_____

Other: _____

