

Medication Credit Card

Name: _____

Date of Birth: _____

Allergies: _____

Doctor: _____

Pharmacy: _____

Medical History: _____

Drug /Dose When do you take it?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Monthly Blood Pressure Record:

Normal Pressure:

120/80 or lower

At risk: 120-139/80-89

High pressure: 140/90 or higher

Month	Systole (top)	Diastole (bottom)
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

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