PARKINSON
ASSOCIATION OF ALABAMA, INC.

# My Medications

Complete this form and keep them available to share at the hospital, doctor's appointments, and any other times when you need to share medication lists. Be sure to keep this form updated any time you have a medication change.

NAME: _____ YEAR DIAGNOSED:_____

| **Important Contact Information** | | |
|---|---|---|
| Care Partner: | Relationship: | Phone/Email: |
| Primary Care Physician: | Phone: | Email: |
| Pharmacy: | Address: | Phone: |

Please note by marking with an "x" if any of the following special considerations should be noted and shared with medical teams:

| | |
|---|---|
| Do you have a deep brain stimulation device? | ___ YES ___NO |
| Do you have Parkinson's disease-related dementia? | ___ YES ___NO |
| Do you easily get dizzy or feel faint? | ___ YES ___NO |
| Do you have special dietary needs? | ___ YES ___NO |
| List any food allergies: | |
| Do you have a Duopa Pump? | ___ YES ___NO |
| Have you had any recent falls? | ___ YES ___NO |
| Do you experience trouble swallowing?<br><br>Have you experienced hallucinations or delusions with PD? | ___ YES ___NO<br><br>___ YES ___NO |
| Do you ever feel disoriented or confused? | ___ YES ___NO |
| Do you have any of the following Non-PD Conditions? | ___COPD ___Depression ___Diabetes<br>___Heart Disease ___Hypertension<br>___ Osteoarthritis ___ Melanoma __Other |

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Use this chart to list all medications you are taking for PD and other conditions, including over-the counter medications and supplements:

| | |
|---|---|
| Do you currently have any medication allergies? | ___ YES ___NO<br>List:_____ |

| TIMES ADMINISTERED | MEDICATION NAME | DOSAGE | NOTES |
|---|---|---|---|
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Make copies of this page if more medications are needed. For additional copies or questions contact Ellen Hicks at ellen@parkinsonassociation.org