



P.O. Box 590146 – Birmingham, AL 35259 – 1.833.473.5465

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My Medications

Complete this form, make copies, 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?	___ YES ___ NO
Have you experienced hallucinations or delusions with PD?	___ YES ___ NO
Do you ever feel disoriented or confused?	___ YES ___ NO
Do you have any of the following Non-PD Conditions?	___ COPD ___ Depression ___ Diabetes ___ Heart Disease ___ Hypertension ___ Melanoma ___ Osteoarthritis ___ Other: _____

