MY MEDICATION LIST

Date Form Updated:_____

Name:	Primary Doctor:	Phone:
Birth Date:	Other Doctor(s):	Phone:
Phone Number:	Primary Pharmacy:	Phone:
Emergency Contact (name & phone):	Other Pharmacy(s)	Phone:

List All Allergies (Medication or Food)

Allergic to:	**Describe reaction**	**Allergic to:**	**Describe reaction**

List All Prescription Medications, Over-The-Counter Medicines, Herbal Supplements or Vitamins You Take (continue on second page if needed)

Date Started	**Name of Medicine & Strength** (ex. mg, units…)	**How to take** (ex: take 1 tablet by mouth 2 times daily)	**What time of day do you take the medicine?**					**Why are you taking this medicine? Or comments**
			Morning	Noon	Dinner	Bedtime	As needed	

Please keep this form updated. Bring it with you to medical appointments.

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			Morning	Noon	Dinner	Bedtime	As needed	