My Medication List

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.

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	