MY MEDICATION LIST

Date Form Updated:	

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

List All Allergies (Medication or Food)

Allergic to:	ergic to: Describe reaction		Describe reaction

List All Prescription Medications, Over-The-Counter Medicines, Herbal Supplements or Vitamins You Take

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