

# My Medication List

*Keep This Form in Your Wallet or Purse for Your Safety*

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Primary Physician/Phone Number: \_\_\_\_\_ / \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Primary Pharmacy/Phone Number: \_\_\_\_\_ / \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Emergency Contact/Phone Number: \_\_\_\_\_ / \_\_\_\_\_  
 Date I Last Updated This Form: \_\_\_\_\_

## MY PRESCRIPTION MEDICATIONS

Start Date	Medication Name	Strength <i>(e.g., 250 mg)</i>	Directions for Use		Route/ Method <i>(e.g., by mouth; inhaled; injectable; by eye drop)</i>	When Do You Take This Medicine? (Check one)					Why Do You Take This Medicine?	Date of Change		Name and Number of the Physician who Prescribed this Medication	
			Dose <i>(e.g., 2 pills or 1 puff)</i>	How Often <i>(e.g., once daily)</i>		Morning	Noon	Dinner	Bedtime	As Needed		Stopped	Changed		

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## MY MEDICATION ALLERGIES

I am allergic to these medications: \_\_\_\_\_ This is the allergic reaction I have to these medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MY OVER-THE-COUNTER MEDICINES

I take the following over-the counter medicines (e.g., aspirin, antacids): \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MY HERBAL MEDICINES

I take the following herbal medicines (e.g., ginseng, ginkgo): \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MY VACCINES

I have had the following vaccinations: \_\_\_\_\_ Date(s): \_\_\_\_\_  
 Pneumococcal (pneumonia) \_\_\_\_\_  
 Influenza (flu) \_\_\_\_\_  
 Tetanus \_\_\_\_\_

## MY VITAMINS

I take the following vitamins: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_