My Medication List

Name : _____

Doctor : _____ Phone : _____

Pharmacy : _____ Phone : _____

List all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies.

Medication Name/ Date Started	**Dose** (mg, units, drops)	**When Take** (daily, at bedtime, etc.)	**Reason for Taking** (blood pressure, diabetes, etc.)