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 *(e.g., 250 mg)*	Directions for Use		Route/ Method *(e.g., by mouth; inhaled; injectable; by eye drop)*	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 *(e.g., 2 pills or 1 puff)*	How Often *(e.g., once daily)*		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, gingko): **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:**

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________