MY MEDICATION LIST

Name:	
Date of birth:	Date prepared:
PCP name:	PCP phone #:

This medication list may help you keep track of your medications and how to use them the right way.

Instructions:

❯ Use this blank form to add prescription medications, over the counter drugs, herbal products, vitamins, and minerals.

❯ Cross out medications when you no longer use them. Then write the date and why you stopped using them.

❯ Ask your doctors, pharmacists, and other healthcare providers to update this list at every visit.

❯ If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

Allergies to medications:	

Drug name:	How I take it:
Doctor:	
What I use medication for:	
Notes:	

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Doctor:	
What I use medication for:	
Notes:	

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If you have any questions about your medication list, call your physician or pharmacist.

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Doctor:	
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