# My Medication List

## My Personal Information
- **Name**: 
- **Date of Birth**: 
- **Phone Number**: 

## Emergency Contact
- **Name**: 
- **Relationship**: 
- **Phone Number**: 

## Primary Care Provider
- **Name**: 
- **Phone Number**: 

## Pharmacy
- **Pharmacist**: 
- **Phone Number**: 

## Other Providers/Contacts
- **Name**: 
- **Specialty**: 
- **Phone Number**: 

## My Allergies (list reaction and severity)

## My Medical Conditions

## How to Use:
- Fill in all fields if possible.
- Update any changes as needed, including any over the counter drugs, herbal supplements or vitamins.
- Share this information with your doctors and pharmacists at every visit.
- Keep a printed copy with you at all times.

*If English is not your primary language, consider having this form translated*

You should review this record when you
- Start or stop a new medicine.
- Change a dosing.
- Visit your doctor

Last Updated (Date):
<table>
<thead>
<tr>
<th>What I’m taking</th>
<th>Form (pill, injection, liquid, patch, shape, color etc.)</th>
<th>Dosage</th>
<th>How Much and When</th>
<th>Use (regularly or as needed)</th>
<th>Start/Stop Dates</th>
<th>Notes, Directions, Reasons for Use</th>
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*Include all prescription drugs, over the counter (OTC) drugs, vitamins, and herbal supplements*