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 _____

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):

Other Providers/Contacts

Name _____

Specialty _____

Phone Number _____

Name _____

Specialty _____

Phone Number _____

Name _____

Specialty _____

Phone Number _____

My Allergies (list reaction and severity)

_____

_____

_____

My Medical Conditions

_____

_____

_____

_____

_____

_____

	What I'm taking	Form (pill, injection, liquid, patch, shape, color etc.)	Dosage	How Much and When	Use (regularly or as needed)	Start/Stop Dates	Notes, Directions, Reasons for Use
Include all prescription drugs, over the counter (OTC) drugs, vitamins, and herbal supplements							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							