My Medication List

My name:_____ **My birth date**:_____

My emergency contact
Name:_____ Phone:_____

Names and phone numbers of my health care providers
Name:_____ Phone:_____
Name:_____ Phone:_____
Name:_____ Phone:_____

Name and phone number of my pharmacy
Name:_____ Phone:_____

My allergies (medicines, foods, and others, such as bee stings or latex)
I am allergic to_____. My reaction is_____.
I am allergic to_____. My reaction is_____.
I am allergic to_____. My reaction is_____.
(If you need more space to write your allergies, use the back of this page.)

My health problems

_____
_____

My medicines
Include **ALL** your medicines, even over-the-counter (OTC), vitamins, and supplements. When you start taking a new medicine, write the date you start. If you stop taking a medicine, cross it off and write the date you stop. Keep this form with you. Bring it to office visits, the pharmacy, or if you get admitted to the hospital.

Name of medicine (start or stop date)	**Reason I take it**	**Dose**	**When I take it**	**What it looks like**
Example: Aspirin (started 10-16-12)	For my heart	81 mg (1 pill)	Once a day	White, round

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Name of medicine (start or stop date)	Reason I take it	Dose	When I take it	What it looks like