

My Medication List

Name: _____ Date: ____ / ____ / ____

Emergency Contact: _____

You can help make your health care safer by keeping this list up to date. Review and change this list when medicines are stopped, doses are changed or new medicines are added. Give this list to any doctor or healthcare provider caring for you. Carry this information with you at all times in case an emergency happens.

Please list all prescriptions (those you get from your pharmacist), over the counter medicines (those you buy from your drugstore), injections, vitamins, herbs, dietary supplements, oxygen use, inhalers and home remedies.

Medication Name	Condition	Dose	Prescribing Doctor	Noticeable Side Effects
1.				
Known Interactions & Depletions:				
2.				
Known Interactions & Depletions:				
3.				
Known Interactions & Depletions:				
4.				
Known Interactions & Depletions:				
5.				
Known Interactions & Depletions:				
6.				
Known Interactions & Depletions:				
7.				
Known Interactions & Depletions:				
8.				
Known Interactions & Depletions:				